

June 1961

Mental Hospitals

Hospital Journal
of the American Psychiatric Association



The Hospital Farm: *Boon or Bane to Patients?*
see page 22.

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INDICATIONS: 'Stelazine' relieves anxiety, whether expressed as hyperactivity or as apathy. It also produces rapid response in many diagnostic categories, including acute and chronic schizophrenias, manic-depressive psychoses, involutional psychoses, chronic brain syndrome and mental deficiency.

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Adult Dosage for Use in Psychiatric Practice

oral (for office patients and outpatients with anxiety): The usual starting dosage is 1 mg. or 2 mg. b.i.d. In the treatment of these patients, it is seldom necessary to exceed 4 mg. a day. (Some patients with more severe disturbances, and discharged mental patients, may require higher dosages.) In some patients, maintenance dosage can be reduced to once-a-day administration.

oral (for patients who are either hospitalized or under adequate supervision): The usual starting dosage is 2 mg. to 5 mg. b.i.d. (Small or emaciated patients should always be started on the lower dosage.)

The majority of patients will show optimum response on 15 mg. or 20 mg. daily, although a few may require 40 mg. a day or more. It is important to give doses that are high enough for long enough periods of time—especially in chronic patients.

Optimum therapeutic dosage levels should be reached within two or three weeks after the start of therapy. When maximum therapeutic response is achieved, dosage may be reduced gradually to a satisfactory maintenance level.

intramuscular (for prompt control of severe symptoms): The usual dosage is 1 mg. to 2 mg. ($\frac{1}{2}$ -1 cc.) by deep intramuscular injection q4-6h, p.r.n. More than 6 mg. within 24 hours is rarely necessary. As soon as a satisfactory response is observed, oral medication should be substituted at the same dosage level or slightly higher.

Only in very exceptional cases should intramuscular dosage exceed 10 mg. within 24 hours. Since 'Stelazine' has a relatively long duration of action, injections should not be given at intervals of less than 4 hours because of the possibility of an excessive cumulative effect.

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Dosage for Psychotic and Mentally Defective Children

The dosages given below apply to children, ages 6 to 12, who are either hospitalized or under adequate supervision.

oral: The starting dosage is 1 mg. administered once a day or b.i.d., depending on the size of the child. Dosage may be increased gradually until symptoms are controlled or until side effects become troublesome. Both the rate and the amount of dosage increases should be carefully adjusted to the size of the child and the severity of the symptoms, and the lowest effective dosage should always be used. Once control is achieved, it is usually possible to reduce dosage to a satisfactory maintenance level.

In most cases, it is not necessary to exceed 15 mg. of 'Stelazine' daily. However, some older children with severe symptoms may require, and be able to tolerate, higher dosages.

intramuscular: There has been little experience with the use of 'Stelazine' Injection in children. However, if it is necessary to achieve rapid control of severe symptoms, 1 mg. ($\frac{1}{2}$ cc.) of 'Stelazine' may be administered intramuscularly once or twice a day, depending on the size of the child. Once control is achieved, usually after the first day, the oral dosage forms of 'Stelazine' should be substituted for the Injection.

SIDE EFFECTS: In the dosage range of 2-4 mg. daily, side effects from 'Stelazine' are infrequent. When they do occur, they are usually slight and transitory. Mild drowsiness occurs in a small percentage of patients; this usually disappears after a day or two of 'Stelazine' therapy. There are occasional cases of dizziness, mild skin reaction, dry mouth, insomnia and fatigue; rarely, neuromuscular reactions (extrapyramidal symptoms).

In hospitalized psychiatric patients receiving daily 'Stelazine' dosages of 10 mg. or more, clinical experience has shown that, when side effects occur, their appearance is usually restricted to the first two or three weeks of therapy. After this initial period, they appear infrequently, even in the course of prolonged therapy. Termination of 'Stelazine' therapy because of side effects is rarely necessary.

Side effects observed include dizziness, muscular weakness, extrapyramidal symptoms, anorexia, rash, lactation and blurred vision. Drowsiness has occurred, but has been transient, usually disappearing in a day or two.

Extrapyramidal Symptoms

These symptoms are seen in a significant number of hospitalized mental patients receiving 'Stelazine'. They may be characterized by akathisia, by the dystonic type, or they may resemble parkinsonism.

akathisia: Some patients may experience an initial transient period of stimulation or

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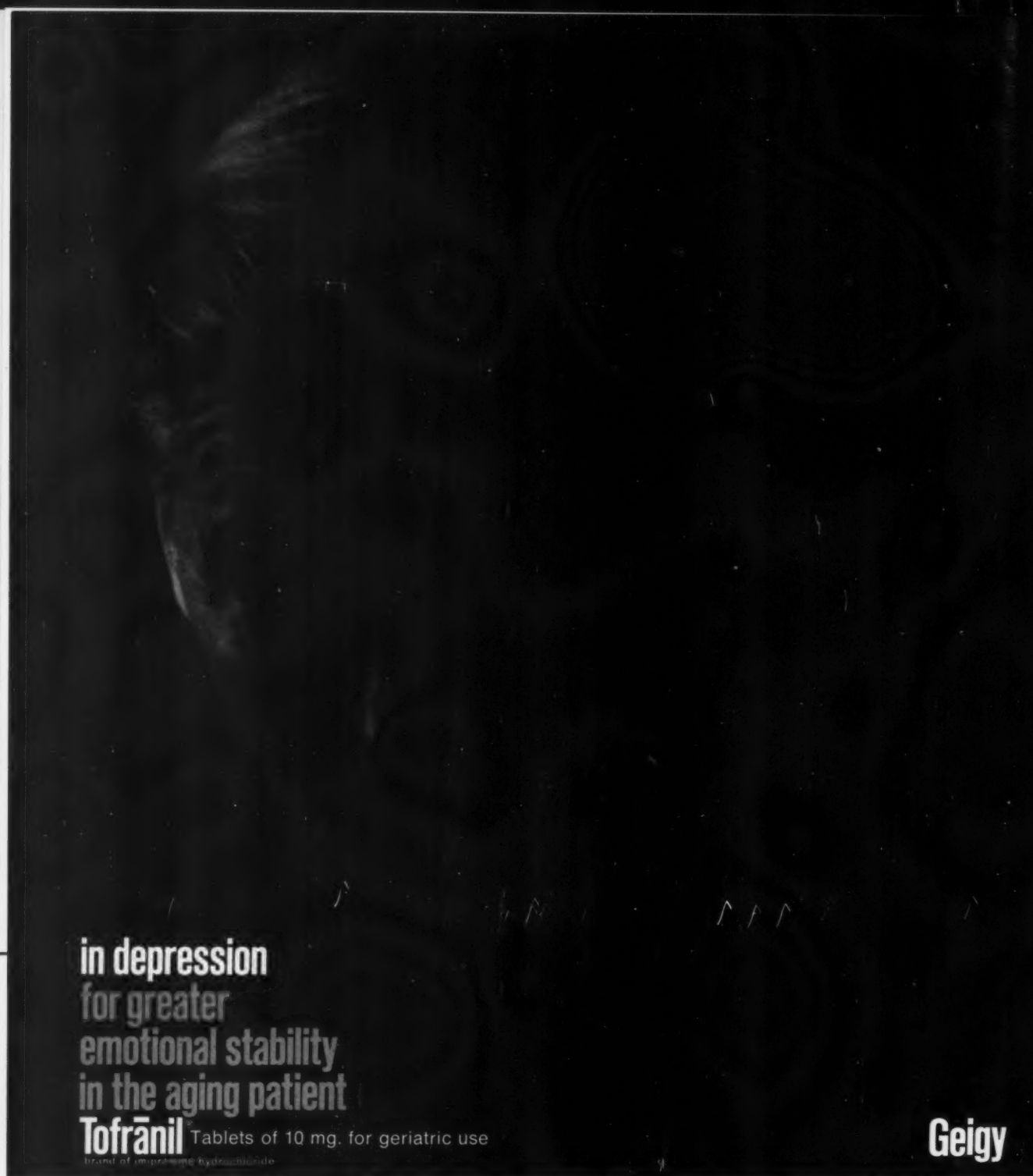
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References: 1. Cameron, E.: *Canad. Psychiat. A. J.*, Special Supplement 4:S160, 1959.

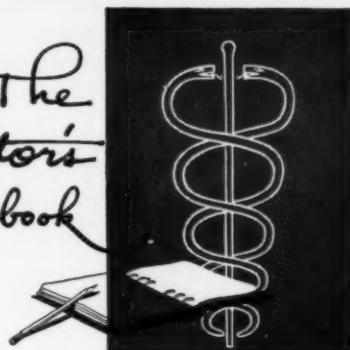
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The Editor's Notebook



"YOU ARE ABOUT TO SEE the most shameful, the most wasteful thing in the country today. People who are sick and miserable, just left to vegetate. Partly, no one knows what to do for them. Mostly, nobody is even trying. They lie on the floor or they sit. They don't do much else. Most of them don't even have shoes to wear, and many haven't been outdoors in years. Maybe it's not too late for some of them. Maybe we can help. But remember this: They are human beings, just like you and me. They have their hopes, aspirations, their fears. They're not monsters. They have their problems, just as you and I have, only theirs are magnified.

"You'll see them now. You'll smell the foul air they must breathe all day. You'll see the rotten chairs they use and the rags they wear. As citizens of this country, I want you to know that I hold each one of you personally responsible for this thing."

With these words a college student, J. Lawrence Dohan, who had been working as a volunteer attendant in a mental hospital, introduced student volunteers to a back ward in the Metropolitan State Hospital, Mass., in 1954. Since that time, the Student Volunteer Project, Phillips Brooks House, Harvard University, has developed a volunteer program involving students from nine colleges and universities in the greater Boston area. Some 2,000 students have taken part. Their main activities have been ward work in groups, supplying recreational and occupational activities, and doing casework to help individual patients make the transition from hospital to community. And last year, Greenblatt and Kantor¹ report, a group of undergraduates established a cooperative halfway house in Cambridge, where both patients and students live together, sharing the problems of "family living," with the purpose of helping these chronic psychotic patients to improve sufficiently to live a full working life in the community.

From the active humanitarianism of a twenty-year-old has come a venture which Greenblatt and Kantor describe as unique in psychiatry. From it, too, have evolved summer work-study programs in mental health for graduates and undergraduates of several colleges and universities.

^{1,2}For references, see Page 21.

This youthful reversal of the "rejection pattern" so vividly documented in the Final Report of the Joint Commission for Mental Illness and Health deserves some careful examination. A certain hardening of the arteries of human compassion is almost an occupational hazard, not only for psychiatrists, but for all mental hospital workers. To some extent all who care for the sick must outgrow oversensitivity, or else they are useless to their patients. In psychiatry the process is at once more subtle and more perilous. The Joint Commission report accuses us all of rejecting the mentally ill to some extent. This is partly due to our human desire to "see results"; therefore, we treat first those patients most likely to improve. Partly, it is because of economic factors—the ninety-nine sheep are more important to society than the dark hundredth. Whatever the reasons, many of us have grown old and sad in the business of treating the mentally ill, especially the chronically mentally ill.

It took a youngster, arrogant if you will, but born free and shocked to his soul at society's hardness of heart, to say "... I want you to know that I hold each one of you personally responsible for this thing." Six years later, another man, mature and sophisticated in the problems of mental illness, said to the Congress of the United States, "... we each have one kind of responsibility that is common to all and transcends all others. This is our responsibility as citizens of a democratic nation founded out of faith in the uniqueness, integrity, and dignity of human life."²

True, as the Joint Commission report says "... the weight of the responsibility, the surfeit of tragedy, sheer numbers, and the years of undermanned efforts are too heavy to be lifted solely by youthful hope and flexibility." Yet the resourcefulness, creative imagination, and enthusiasm of these young people has made, to quote Greenblatt and Kantor again, "formidable and welcome force for progress." And in spite of its cautionary words, the Joint Commission includes in its report a one-sentence recommendation on volunteers which reads simply: "The volunteer work with mental hospital patients done by college students and many others should be encouraged and extended."

The problem then is to team the driving hopefulness of the young with the maturity and sophistication of professional leaders. On a practical level, both the student-volunteer movement and the summer work-study programs for college students are powerful recruiting methods. But their significance transcends this. Even those not drawn to a mental health career will acquire greater understanding of the specific problems of mental illness and some of the remedies needed. More important, they will develop a broader, more merciful humanitarianism. Only in youth can we learn that all men are our brothers. Upon this deep conviction will depend not only the resolution of the tragic problems of mental illness, but the development of a positive, healthy society for all mankind.

Matthew Rose, M.D.

THE PSYCHOLOGIST'S FUNCTION

ON A STATE LEVEL

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VASTLY INCREASED DEMANDS for varied rehabilitative services, coupled with shortages of professional personnel, are impelling mental health and correctional program administrators to reevaluate the traditional functions of their professional staffs. As a result, during the last 15 years, clinical psychologists have steadily assumed larger and more complex responsibilities.

Who is a clinical psychologist, and what services can he render? Today, the term "clinical psychologist" is usually applied only to those who have obtained a Ph.D. in psychology and are scientist-practitioners in the clinical aspects of human behavior. A clinical psychologist, to obtain his Ph.D., must complete at least four years of graduate study and practical field training in one of 56 training programs approved by the American Psychological Association. During his graduate training, he is given progressively more experience and responsibility which equips him to offer services beyond that of a mere "mental tester." In addition, he can achieve Diplomate status from the American Board of Examiners in Professional Psychology after completion of his Ph.D., five years of acceptable experience, and written and oral examinations.

**For purposes of this paper the term "clinical psychologist" and "psychologist" will be used interchangeably. The authors realize the increasingly important roles that other psychologists—social, experimental, and counseling—are playing in the mental health and correctional fields, but will limit their statements primarily to clinical psychologists.*

This report will discuss six major areas of a clinical psychologist's role in Massachusetts as he collaborates with the other "helping professions": diagnosis, psychotherapy, research, education and training, consultation, and administration:

1) Diagnosis: Clinical psychologists have made a major contribution to the diagnostic evaluation of patients. Through testing, they contribute importantly and uniquely to differential diagnosis, personality assessment, and the evaluation of thinking disorders in brain-damaged individuals. Although these services are usually performed at the intake phase, psychologists also help to assess continued-treatment techniques.

In most correctional institutions, the psychologist usually is the only person on the classification board who is trained to make systematic observations of the inmates' emotional problems and controls and provide useful information about their potentials for rehabilitation. By means of special tests he helps hospital patients or prison inmates to plan for educational or occupational activities after discharge.

Examples:

- A seven-year old boy exhibited marked hyperactive, destructive behavior and posed a problem of differential diagnosis. Although the boy's case history was ambiguous in regard to physical or functional problems, the psychologist found test patterns suggestive of organic brain damage. Subsequent EEG studies confirmed these findings.

• A patient was admitted to a hospital and diagnosed as schizophrenic. His schizophrenic episodes had been relatively acute, but because he very quickly regressed to infantile behavior, psychotherapy for him was questionable. Projective tests determined the degree of regression and revealed many personality strengths. These strengths indicated a favorable prognosis if the patient were to receive immediate psychotherapy which would continue over a long period of time. On the other hand, projective tests suggested that a similar patient was less treatable because his basic personality was much more infantile.

• A sex offender was admitted to a correctional institution, and, after diagnostic testing, was placed in both group and individual psychotherapy. Tests were repeated several times throughout the treatment regimen and provided the best objective measure of personality change.

2) Psychotherapy: Psychologists are trained and experienced in both group and individual psychotherapy, and receive psychiatric supervision during their professional training. In community mental health centers for children, they conduct play and activity group therapy and discussion groups for both parents and children. In hospitals or correctional institutions, they provide rapid, emergency psychotherapeutic techniques. In state schools, they give group counseling and educational therapy to patients and assist in vocational planning. While therapy and counseling are important during continued treatment, they are often equally valuable during aftercare, particularly if, in each period, they are performed by the same psychologist.

In a correctional institution, the psychologist may be the only person who is trained in psychotherapy. He conducts both individual and group therapy for inmates who need such assistance to adjust to the institution and, after release, to the community.

Examples:

• A probation officer referred an eight-year-old adopted boy to a community mental health center because the boy repeatedly set fires. A psychologist initiated contact with the boy through diagnostic testing and gave him weekly play therapy for two years. By learning to express his basic problem of self-identity and to accept his adoption, the boy improved markedly and his fire-setting ceased.

• A young adult was admitted to a mental hospital during an acute schizophrenic episode. He seemed to adjust well to the hospital and was placed in intake group psychotherapy, led by a psychologist. He also received individual psychotherapy from a psychiatrist. In the group, the patient was able to reevaluate some of his problems and to compare them with those of other patients. He recovered rapidly and returned to the community within two months. As an outpatient, he continued to visit the hospital for a year for group psychotherapy, and was then discharged.

• A 20-year-old inmate in a correctional institution was placed in permanent segregation because of re-

peated assaultive behavior toward correctional officers and other inmates. A psychologist administered psychotherapy and continued it after the inmate was released from segregation. Although the inmate's basic problems have not been altered, he is making his first successful institutional adjustment in five years and is utilizing other treatment and training programs with an eye to his future release from the institution.

3) Research: Psychologists are trained as behavioral scientists and are experienced in research strategy, design, and methodology. Psychological research, based on significant and answerable questions, provides important information concerning the effectiveness of programs or treatment techniques, flaws in the social climate of a ward or prison which may impede rehabilitation, and the best methods for teaching defective children. A competent research staff obtains special grants from government and other agencies. These grants assist in attracting top-level personnel to institutions.

Examples:

• A mental health center became interested in the epidemiology of local juvenile delinquency. A staff psychologist initiated a project to obtain data about sources and distributions of delinquents in an urban population, and to develop a method of classifying the delinquents. This information provided a basis for developing and deploying services to meet the area's needs.

• A psychologist in the Division of Legal Medicine faced the problem of improving a poor classification scheme and weak diagnostic categories for a wide variety of patients. He developed techniques which enabled agency personnel to better understand the kinds of patients with whom they dealt. He outlined schedules to assess and more precisely diagnose these patients, to provide better means of program evaluation, and to facilitate realistic program planning for the future.

• The psychologist in a state hospital gathered information about the hospital's patient-population by means of objective observations. This information became the basis for developing specific hypotheses which could be evaluated by psychological tests and other methods. Results assisted the hospital to better understand the type of patient-population with which it was dealing and to provide more suitable treatment techniques.

4) Training and Education: With regard to hospital inservice training, psychologists provide courses, group discussions, lectures, and special programs for nurses, psychiatrists, social workers, and lay personnel. Psychologists play key roles in community mental health education programs; they plan, organize, and conduct programs to explain mental health principles, human development, and the nature of mental disorders. In correctional institutions, psychologists develop mental health training programs for correctional officers and educational groups for inmates.

Psychologists also help to train graduate students and new psychologists by supervising diagnostic testing,

psychotherapy, consultation, and research. Such training programs, developed in close liaison with accredited universities, often channel new personnel into the state's mental health and correctional programs.

Examples:

- Officials of a mental health association asked the staff of a community mental health center to coordinate educational programs with the association's membership drive. The center's psychologist directed a program of movies and guest speakers on the theme of "normal child development." As a result, discussion groups were started with parents, bringing about better communication between the mental health center and the community.
- The psychologist at a state hospital developed an intern program for graduate psychology students at a local university. From this program he obtained extra psychological services and potential staff members for the hospital, and was able to initiate important research projects. He in turn has been stimulated by his participation in the training program and by teaching at the university.
- A psychologist in the Division of Mental Hygiene, who had public health training, developed an inservice training program to orient new professional personnel to public health aspects of community mental health.

5) Consultation: Psychologists have demonstrated their skills in practicing the specialized techniques of mental health consultation. In community mental health centers, they develop contacts with professional agencies that care for large groups of children and give crisis consultation on children's specific adjustment problems. As an outgrowth of their consultant roles, psychologists also act as case-finding agents. In this way, without themselves getting involved in long-term treatment and case follow-up, they help other professional workers to use their own skills more effectively.

In the hospital, psychologists provide specialized consultation and technical assistance to various types of personnel. They assist the administrator of a hospital or correctional institution to improve programming. In many agencies, psychologists function as consultants to other professional workers in areas such as diagnosis, research, psychotherapy, and administration.

Examples:

- A teacher was going to exclude a seven-year-old boy from the first grade because she was unable to control his aggressive behavior. She requested consultative help from the local mental health center. The psychologist consultant recognized the teacher's personal over-involvement in the problem and helped her to see the child's behavior as an understandable reaction to deprivation and rejection at home. No longer threatened and upset, the teacher was able to use her habitual skill in handling problem children, and helped the boy to settle down and do better in school.
- A hospital superintendent was faced with the problem of developing a high-level training hospital. Be-

cause his psychology department was weak, he asked a psychologist consultant from a central department to discuss various methods of enhancing his program. During meetings over a period of five months, the consultant helped the superintendent to develop a better staff through more extensive inservice training and closer liaison with training universities. This in turn produced a more stimulating and challenging program for the entire hospital.

- A new superintendent of a correctional institution wanted to improve the morale of staff and inmates by developing a counseling program. A psychologist consultant from the Division of Legal Medicine met with the superintendent to evaluate the institution's counseling needs and decide how to put necessary services into action. The consultant helped the superintendent to develop a personnel-training program, an alcoholism clinic, and individual and group therapy programs, utilizing mental health workers from both the institution and the Division.

6) Administration: The role of psychologists in administration is a new and expanding one. Their theoretical knowledge, research training, and experience qualify them to organize and administer programs of clinical, consultative, and educative services. They also provide specific services to administrators, such as personnel evaluation and screening, and program analysis.

In the Division of Mental Hygiene, psychologists are administrators of some community mental health centers, maintaining liaison with community leaders and other agencies concerned with mental health. In hospitals, psychologists serve as administrative officers of wards or larger sub-sections, taking responsibility for the daily routine management of patient-activities and care. Psychologists are administrators of outpatient services or follow-up services of hospitals and state schools. Their administrative duties include the direction of psychology departments where they recruit personnel and take charge of program planning and training programs. They also coordinate particular aspects of their departmental programs with other segments of the total hospital program.

A psychologist directs a state-wide, multi-discipline program of nursery centers for mentally retarded children. Others assist in developing similar broad programs in the Division of Legal Medicine.

Psychologists in the correctional field function as deputy commissioners, administering a department-wide personnel and inservice training program or a classification and treatment program. They serve as institution superintendents, associate wardens or directors of treatment, and as administrators of specific clinical facilities.

Examples:

- A psychologist was named executive director of a community mental health center in the Division of Mental Hygiene. He assumed responsibility for the center's finances and its professional staff functions and standards; liaison with the local mental health association, mental health board, and care-taking agencies; and development of a total community mental health

program. During a two-year period, the psychologist's position became well defined and highly accepted in the community, facilitating even closer relationships between the community and the mental health center. The center also became a training agency for a large university training program.

- A psychologist in a large state hospital developed a major training and research program in collaboration with a local university's psychology training program. Through his administrative skill, he was able to develop pre-doctoral and post-doctoral training programs and a number of research programs which were subsidized by federal funds. These provided much-needed

services for the hospital and guaranteed a pool of prospective employees. The psychologist also served as administrative assistant to the hospital's superintendent, taking charge of specific aspects of program development.

- A clinical psychologist in the Department of Mental Health, functioning in relation to correctional problems, was promoted to a top administrative position in the Department of Correction where he could apply his skills in enhancing and developing the total treatment and classification program. Another psychologist is administrator of all personnel and training programs in the Department of Correction.

THE DOCTOR'S DILEMMA

By Dr. WHATSISNAME

THE GENERAL PRACTITIONER has a fairly clean-cut line of responsibility to his patients. His sworn duty is to do what is right for them, but when he puts a patient in a general hospital, he does not have to worry about the institution's administration.

The hospital staff psychiatrist, however, has a double responsibility which sometimes puts him on the horns of a dilemma. On the one hand, he is responsible to his superiors and to the institutional mores. On the other hand, he has a sworn responsibility to his patient. In some settings, he has even taken two oaths which might be conflicting. For example, in an army hospital the doctor, when commissioned, pledges himself by all that is holy to obey the orders of the officers above him. Presumably, he also has taken the Hippocratic Oath, which imposed on him a moral responsibility to concentrate on the welfare of his patients. It is conceivable that where these pledges conflict, the doctor may find himself faced with the choice of breaking one oath or the other.

In a public mental hospital, the situation is not quite so dramatic; but here, too, the doctor on the staff has a moral and legal responsibility to his senior officers as well as to his patients. He can often be torn between the two responsibilities. For example, the doctor may want to grant a patient some additional freedom that would help the patient, but might also disturb the peace of the hospital. Or, he may want to do something beneficial for the patient, knowing that his act would violate a hospital regulation, but believing that under the circumstances the rule is a foolish one. Senior officers, however, could say that they want the rule to be observed merely because they do not want to set a precedent. It is even possible that it would be in the best interest of a patient to permit him to send a letter which the hospital censor might want to block; in this situation the ward physician would have a very real conflict of loyalties.

In Bernard Shaw's play, "The Doctor's Dilemma," the physician was faced with deciding which of two patients to save with a limited supply of a drug. When a doctor has the skill to perform psychotherapy in a mental hospital, he is faced with a dilemma like this every

day. He has to decide who among a vast number of patients is going to get this service. He is also confronted with the fact that the more time he spends on psychotherapy, the less time he is going to have to take care of the many other patients in his caseload—a load which easily may exceed 200. Under these circumstances, too, the doctor has a difficult choice.

In an extreme situation, one even can conjure up a problem where a ward doctor is firmly convinced that a patient is not psychotic and should be released, but where the staff has voted otherwise. Thus, the ward physician is in the very painful position of either completely defying authority and effecting the patient's release or completely breaching his own conscience and allowing the patient to remain in the hospital. Faced with such a dilemma, he can probably think only of the old cliché: "There must be easier ways of making a living."



THE HOSPITAL PSYCHOLOGIST— PRESENT PROBLEMS AND FUTURE SOLUTIONS

By ALEXANDER TOLOR, Ph.D.

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THE SCARCITY of well-trained psychiatrists, psychologists, and social workers in our mental institutions has reached staggering proportions. In part, this shortage is due to the reluctance of many professionals to work in mental hospitals; they have multiple, well-founded reasons for employing their talents elsewhere. This paper will focus on the special problems encountered by clinical psychologists in mental hospitals; although, some of its conclusions may have relevance to other professions as well. The author presents this analysis with the hope that it might inspire corrective measures to overcome some of the major reservations that many psychologists have about functioning in a mental hospital.

There are several commonly mentioned sources of job dissatisfaction, such as relatively low salaries imposed by the hospital's limited budget and the frustrating amount of institutional red tape. But this discussion will be restricted to a consideration of the professional aspects of the clinical psychologist's work.

The typical graduate from a sound doctoral program in clinical psychology seeks in his job an opportunity to develop his scientific understanding of the behavior of living organisms. He will be attracted to and remain with the kind of mental hospital that permits him to exercise his skills and pursue his interests in a personally and socially rewarding manner.

One of the psychologist's major clinical skills is that which enables him to formulate a dynamically oriented evaluation of a disturbed individual's personality. In doing so, he relies heavily on his understanding of psychopathology; his ability to evaluate and integrate relevant research data; and his competency to use psychodiagnostic techniques, such as special tests and interview methods. Potentially, this function is one of the most rewarding, interesting, and genuinely significant to the psychologist; unfortunately, when practiced in a mental hospital setting, it also can be the source of a great deal of dissatisfaction.

Many times the hospital psychologist is inundated by a large volume of referrals for evaluation. Too often, referrals are prompted by nothing more than a desire to fulfill certain technical requirements or a supervisor's wishes, without much appreciation on the part of the referring source of the amount of time and energy re-

quired to prepare a single thorough evaluation. Moreover, the failure of the referring source to understand what can and what cannot be accomplished by psychological evaluations sometimes leads him to present problems that defy solution.

Frustration and Isolation

The psychologist may respond with frustration to the discrepancy existing between what reasonably may be expected of him and the need of the referring physician. He also may respond to unreasonable expectations by making unwarranted or sweeping conclusions as a defense against appearing to be ignorant or inadequate in the eyes of professional colleagues.

Another difficulty arises when psychologists sometimes fail to derive an experience of closure in work with hospital patients and may even begin to perceive themselves as interlopers in the patient-physician relationship. This self-perception results when hospitals exclude psychologists from intake conferences and fail to provide them with constant feedback information concerning the patient's course, both during hospitalization and after discharge, as well as significant developments in psychotherapy. Under these conditions it is small wonder that patients' names and faces can become meaningless to the psychologist and that he eventually may visualize patients more as psychograms than as real persons.

In some hospitals, the psychologist may feel that his evaluations and suggestions are given little weight in psychiatric staff decisions and, therefore, represent virtually useless intellectual exercises. When the psychologists' reports are used primarily to confirm psychiatric impressions which will prevail irrespective of deviant psychological findings, the pressure on the psychologist to arrive at an agreement with the psychiatric findings and to disregard psychological test data becomes an important factor in dissatisfaction. Moreover, the work then becomes routine, tedious, and objectionable to the more talented psychologists.

In the role of psychotherapist, the psychologist's primary dissatisfaction with mental hospital work springs from the lack of coordination between the various professions, especially between the therapist and the medical administrator. Too frequently the phrase "team ap-

proach" has a hollow ring in the mental hospital and becomes a travesty on the philosophy of a well-coordinated approach. The large number of patients who receive some type of drug treatment in conjunction with psychotherapy underscores the importance of integrating psychotherapeutic interventions with ongoing somatic treatments. The absence of such unified planning often produces deleterious effects which may discourage the psychotherapist who is working toward specific goals with his patient. Similarly destructive consequences may result when, without prior consultation with the therapist, the staff reassigns a patient from one type of ward to another or from one activity program to another.

The need to understand all of the possible effects of administrative decisions concerning the patient makes it vital to keep lines of communication open among the staff. When the therapist and the administrator do not enjoy a constant exchange of viewpoints, they are bound to suffer a variety of misconceptions about each other's intentions.

A special situation occurs when a psychologist functioning as a group therapist is deprived of a voice in making administrative decisions. As we all know, during group-therapy sessions, psychotic patients devote considerable time to discussing administrative policies, such as those relating to open or closed wards, the menu, and ground privileges. Admittedly, the therapist should avoid being sucked into the pros and cons of such issues as far as possible. However, if he is unable to participate in discussions with a flexible administrative staff, his position with the patients is seriously undermined, and his own morale is lowered.

Neglected Research Talents

Research is one of the psychologist's areas of special training and competence; therefore, it should be a particularly attractive activity to him and yield much in the way of job satisfaction. But, the less-than-enthusiastic attitude of many hospital psychologists is reflected in the relatively meager and unimportant clinical research being carried out in their field. This, too, can be traced back to institutions that have failed to provide full support and cooperation to those who are most interested and talented in performing research.

Too many mental hospitals still assign primary importance to the so-called "service functions," even though they could benefit from gaining reputations as research centers and from the general enlightenment that accompanies scientific investigation. Thus the time allotted to research—even when the administration considers it to be a legitimate part of the psychologist's duties—is often so limited that only very superficial, non-complex, and unrelated problems may be tackled.

The hospital psychologist's excessive emphasis on test-oriented research is caused partially by the inaccessibility of clinical data in some hospitals and the disinterest of other professional personnel who may be too caught up in their own pressing needs to provide services. Test-oriented research probably adds little to the resolution of basic mental health problems. The elucidation and refinement of psychologists' diagnostic instruments rep-

resent goals far short of their hopes, but even these limited goals are often denied the clinician who is deprived of the staff cooperation necessary for an adequate study.

Other special problems are engendered by the relatively low professional status enjoyed by state, federal, or private-hospital clinical psychologists as compared to that of private practitioners or university clinical psychologists. The private-practice clinician enjoys a high degree of independence in his work and often achieves a much greater monetary reward than does the hospital psychologist. The psychologist in a university is spared many of the interprofessional rivalries existing in hospital settings; in most instances, he also is provided with unusual opportunities for further professional growth and intellectual stimulation which the hospital may not offer.

Some of this status differential can be reduced by hospitals providing an ample supply of outside consultants and permitting psychologists to participate in the training of other professionals. Clinical psychologists should participate to the fullest extent in the training of psychiatric residents if an adequate foundation for understanding the clinical psychologist's functioning is to be insured. Sometimes residents resist such exposure since their expectations and the psychologists' self-perceptions seem to differ greatly.

The Ideal Situation

What kind of mental hospital, then, represents a desirable place of employment to a psychologist?

First, this model hospital promotes close integration of the clinical psychologist's activities with those of other professionals. In psychodiagnosis, it provides a team approach in fact rather than in theory by promoting the exchange and proper use of information. From the very start it welcomes the psychologist as an integral part of the evaluating team and its staff consults with him when important decisions are made.

In the ideal mental hospital, the psychologist maintains contact with the patient during the course of hospitalization and automatically receives any available follow-up information. Referrals for testing are well conceived, with due appreciation given to the strengths and weaknesses of psychological assessment techniques. Most important, the psychologist's findings are given equal consideration when a treatment program suited to the patient's needs is being formulated.

This model mental hospital, by closely coordinating administrative and therapeutic procedures, also encourages the psychologist to assume greater responsibility in the treatment program. (An example of this is the recent policy prevailing at many VA hospitals which permits psychologists to assume some of the administrative and psychotherapeutic responsibilities for patients on the wards.) Somatic treatments are well integrated with psychotherapy. Communication between the various disciplines flows freely and frequently.

The more attractive hospital encourages research by providing ample time, facilities, and professional support. Clinical material is readily available. The staff is acutely aware of the need for cooperation. The adminis-

trator considers coordination of the service staff and the research staff to be vital, especially in research where patients' somatic treatments or social contacts represent variables that must be controlled carefully.

The desirable mental hospital attempts to attract personnel by making the work situation a continuous learning process. It permits competent personnel to function as teachers or consultants. It encourages a constant infusion of ideas from the outside to prevent inbreeding and stagnation of thinking among staff members. It helps clinical psychologists to institute teaching programs which permit them to make important professional contributions and enhances their professional status.

The clinical psychologist in such a hospital might function in an advisory capacity to the administration concerning such matters as the selection of personnel and the morale of hospital employees. He also might assist in establishing closer liaison between the community and the hospital, thereby working toward improvement of public relations.

Two recent developments in mental hospital patient-care may have further profound influences on the clinical psychologist's future activities. First, the higher discharge rate and the more rapid turnover of hospitalized patients suggests that the harried psychiatrist and psychologist will have progressively less time to spend with any one patient. Consequently, the psychologist should

be encouraged to supply intensive training to attendants and nurses who have the most frequent daily contact with patients and, therefore, wield the most influence for better or worse. The psychologist should be urged to adjust his assessment techniques to make them more consistent with the patient's expected stay in the hospital or likely exposure to psychotherapeutic interventions; this would eliminate superfluous testing and provide a better opportunity for a thorough evaluation when indicated.

The second current trend of major significance to psychologists is that of locating new, smaller mental hospitals within the community rather than in isolated rural areas. The implication of this change for hospital psychologists is that they may consult with the patient and his family in the patient's home before hospitalization and prior to or after discharge. Such home visits would permit psychologists to make unique contributions which would extend beyond those made by social workers. Moreover, this approach would open unlimited new vistas for research.

The possibility exists of liberating numbers of well-trained, preventively-minded psychologists from the confines of the hospital office and pitting them more directly against the problems of mental illness. Within this possibility lies the mental hospital's brightest hope for attracting and retaining the clinical psychologist of the future. •

Have You Read?

YOUR NURSING SERVICES TODAY AND TOMORROW, by Elizabeth Ogg, in cooperation with the National League for Nursing. The advance in modern medicine and the consequent reorganization of our health services has brought about a basic change in the job of the professional nurse. Miss Ogg stresses, "The nursing team, with each member trained for the tasks assigned to her and alert to the emotional as well as the physical aspects of illness, gives you far more help than you could have expected thirty years ago from one nurse."

"The rise of the nursing team is only one change that has taken place," the author continues. "There are many others, and new ones are coming along every day—new discoveries and developments that make . . . medical and nursing care more effective."

Among the new developments covered in the pamphlet are progressive patient-care and organized home-care programs. The reader is reminded of the seven-point patient's bill of rights published by NLN; one of these points is that "a patient has the right to expect that he will receive the nursing care necessary to help him regain or maintain his maximum degree of health; that the nursing personnel who care for him are qualified, through education, experience, and personality, to carry out the services for which they are responsible."

This 25-cent booklet is No. 307 in the series pub-

lished by and obtainable from the Public Affairs Committee, 2 East 38th Street, New York 16, N. Y.

PUBLISH WITH A PURPOSE, by Richard C. Thompson, in the February 1, 1961, issue of *Hospitals*. Any publishing program has problems, including those related to the trade. But the author notes that hospital publications have a unique set all of their own because of the wide audience they serve. He presents an analysis of hospital publications and some suggestions for content, layout, and design. Among the various categories of hospital publications he mentions are "patient information," "employee information," "hospital newspaper," "annual report," "institution report," and one unto itself—"fund-raising information."

THE MENTAL HOSPITAL AND THE EMOTIONALLY DISABLED EMPLOYEE, by Henry A. Davidson, M.D., in the November 1960 issue of *Nursing Outlook*. Does the modern mental hospital have a moral or professional obligation to employ the person who is emotionally disabled? "This question," says Dr. Davidson, "is a serious one for the administrators, and creates special problems for nursing service, which often carries the major burden of maintaining the best possible service to the patients for the full 24-hour day."



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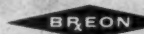
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*Shovlain, F. E.; Brown, R. W.; Delaney, G. A.; and Lelli, F. P.: Hospitals 33:61 (June 1) 1959.

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1. Rappaport, J.: *Cur. M. Dig.* 25:57-62 (Nov.) 1958. 2. Fox, V., and Smith, M.A.: *Quart. J. Stud. Alcohol.* 20:767-780 (Dec.) 1959.

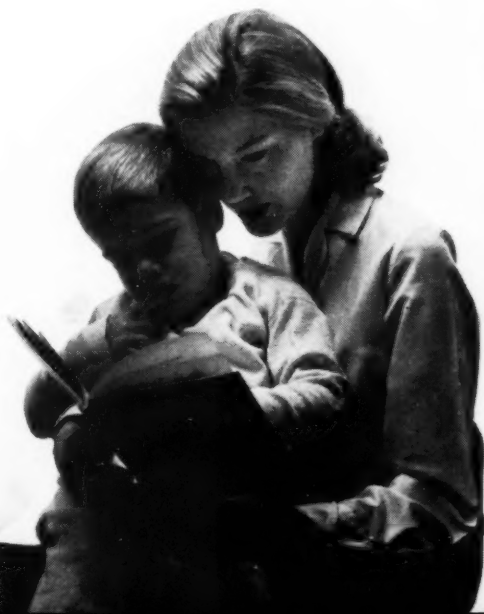
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SPARINE may be used as an aid in diagnostic and therapeutic regimens. Such nonspecific symptoms as anxiety, pain, vomiting, nausea and hiccups frequently make more difficult both diagnosis and therapy of organic disease. SPARINE allays such symptoms without masking physical, neurological or laboratory findings.

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Alcoholism, other Mental and Emotional Disturbances. In the management of agitated patients, SPARINE should be given I.V. in initial doses of 50 to 150 mg. If the desired calming effect is not apparent within 5 to 10 minutes, additional doses up to a total of 300 mg. may be given. Once the desired effect is obtained, SPARINE may then be given I.M. or orally in maintenance doses of 10 to 200 mg. at 4 to 6 hour intervals. In less severe disturbances, initial oral therapy may be satisfactory. When tablet medication is unsuitable or refused, SPARINE Syrup may be used. IN THE ACUTELY INEBRIATED PATIENT the initial dose should not exceed 50 mg. to avoid further depressant effect of alcohol.

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PRECAUTIONS. Although rare, drowsiness, dizziness and transitory postural hypotension may occur. If a vasopressor drug is indicated, norepinephrine is recommended since SPARINE reverses the effect of epinephrine. Agranulocytosis has been reported in only 18 cases in about 3½ million patients. If, however, signs of cellular depression—sore throat, fever, malaise—become evident, discontinue SPARINE, check white blood cell count, and initiate antibiotic and other suitable therapy if indicated. Seizures, reported as occurring during SPARINE therapy, occur usually with rapid large increases in dose and at a daily dosage above 1 Gm. Caution must be exercised when administering SPARINE to patients with a history of epilepsy. Avoid perivascular extravasation or intra-arterial injection, as severe chemical irritation or inflammatory response may result. Because of its facilitating action on analgesics and central nervous system depressants, give them in reduced dosage with SPARINE. Do not use in comatose states due to central nervous system depressants (alcohol, barbiturates, opiates, etc.). Use with caution in patients with cerebral arteriosclerosis, coronary heart disease, or other conditions where a drop in blood pressure may be undesirable.

For further information on prescribing and administering SPARINE see descriptive literature, available on request.



Dr. Saunders Reports on District Branch Growth

John R. Saunders, M.D., Speaker of the Assembly of District Branches, 1960-61, announced at the A.P.A. annual meeting in May that the assembly is now comprised of 52 district branches with a total membership of approximately 7,000. Only two states, West Virginia and Alabama, remain without district branch coverage. Some interest has been expressed in the formation of additional branches in uncovered sections of the transnational A.P.A. area outside the United States.

Edward G. Billings, M. D., succeeds Dr. Saunders as Speaker of the Assembly for 1961-62.

Since the April issue of MENTAL HOSPITALS, several additional district branches have responded to Dr. Saunders' request for news. Those corresponding for the first time are: Nassau (N.Y.), North Carolina, Pennsylvania, Queens County (N.Y.), Tennessee, and Virginia.

The following items are taken from district branch newsletters.

KANSAS—Disaster and Civil Defense

The Committee on Disaster and Civil Defense of the Kansas District Branch has made the following recommendations:

- 1) That officials of mental hospitals continue to review and refine their disaster plans to assure flexibility, provision for the unexpected, clarity, and rehearsal.
- 2) That officials collate their thinking with other hospitals, health agencies and welfare agencies, and Civil Defense authorities to assure a thorough understanding of the role each is to play in the event of a disaster.
- 3) That hospital plans should include provision for the establishment of teams of psychiatrists and psychologists at all receiving stations (psychiatric and nonpsychiatric) for "psychological first aid" in the event of a disaster.
- 4) That all physicians become proficient in the practice of disaster medicine in order to lead and train others in effective self-aid and first-aid lifesaving measures.

MICHIGAN—More on Civil Defense

At a recent meeting of the Michigan Society of Neurology and Psychiatry and the Michigan District Branch, Herbert Raskin, M.D., Chairman of the Committee on

Civil Defense, made a motion that the society write to the Department of Mental Health recommending that a Civil Defense officer be appointed for each mental health facility in the state and be directed to contact local or regional Civil Defense officers to work out plans for the hospitals and the areas they serve.

PENNSYLVANIA—Proposed Change in Trustees' Role

Pennsylvania House Bill 297 is now out of committee and on third reading in the House of Representatives. This bill, if enacted into law, will give the boards of trustees of mental institutions the power to assign, appoint, and dismiss nonprofessional and nonskilled employees of the institutions. This would alter the present advisory role of trustees.

—Separate Department of Mental Health

Last February a bill was introduced to the State Senate advocating a separate department of mental health and cabinet status for the commissioner of mental health. The Pennsylvania Psychiatric Society has endorsed the bill. Among the Society's reasons for supporting the proposed legislation are:

- 1) The magnitude of mental illness and health is so great that the problems require a policy-making official on the highest level.
- 2) An effective mental health program can be run efficiently only as a separate department.
- 3) Traditionally, the focus of the health department has not been and, in fact, is not now on the clinical care of patients, but on prevention. Psychiatry is not ready for this approach alone.

VIRGINIA—General Hospital to Open NP Units

Taking the cue from the successful establishment of psychiatric units in local hospitals in Richmond and Norfolk, general hospitals in several other Virginia communities are developing similar facilities. *Fairfax:* Recently the Fairfax Hospital opened a 10-room open ward psychiatric unit under the direction of Robert Neu, M.D. An adjacent 10-room unit and a large open-roof section are available for expansion. *Arlington:* Plans for the development of a psychiatric unit in the Arlington Hospital were begun recently by formalizing a department of psychiatry, with Alice H. Kiessling, M.D., as acting chief. Further organization is under way. *Lynchburg:* The Virginia Baptist Hospital has a new 12-bed open ward psychiatric unit, which includes an up-to-date dayroom outfitted by the local chapter of the Mental Health Association. The Lynchburg General Hospital is discussing plans for the formation of a department of psychiatry. *Roanoke:* The Roanoke Memorial Hospital is planning a rehabilitation center with a whole floor devoted to the psychiatric division.

Social Group Work with Family-Care Patients

By DORTHEA M. LANE, M.A.

Assistant Chief, Social Work Service

VA Center

Los Angeles, California

and GLADYS SINGERMAN, M.S.W.*

A SMALL NUMBER of chronically ill patients, who had received the maximum benefit from hospital treatment and could not be reached by individual therapy, were living in family-care homes in a semi-rural area in Los Angeles county, where they were quite well accepted by the community. However, we noticed that while these patients had improved when first placed in family care, they had then settled at a rather low level of socialization. In the hospital they had responded to activities planned by various therapists, but such programs could be supplied only intermittently to patients in family care.

We thought that social group work, a method of helping individuals to improve in their social relationships and functioning by means of specially planned group-experiences, might be effective. It has been used successfully in hospitals, clinics, and occasionally with discharged patients, but never with family-care patients as regressed as these.

In order to try the idea we sought and obtained a subsidy from the Ida S. Latz Foundation, Inc., established to serve rehabilitation needs of World War II veterans on a selected basis. The subsidy made it possible for a social group worker to meet twice weekly with a group of family-care patients to help them achieve a more adequate social adjustment and enjoy a fuller, more satisfying life.

Twenty-five men, mainly regressed schizophrenics, were involved in the study project. Living in a family-care home had not been enough to bring them back to normal community living. Eleven remained in the project for over a year and could be evaluated consistently. Nine of these were between 28 and 45; two others were in their 50's. All but two had spent at least 20 per cent of their lives in a psychiatric hospital, and of the two exceptions, both in their 40's, one had been in family care for eight years and the other for three and a half years. Six of the other patients had been in family care

for over three years, while other placements ranged from one to five years. Ten of the men were single, and one divorced. Only one individual had a substantial work history prior to military service, and only one had been well enough to work since discharge from military service. All had received a medical discharge and were service-connected for a psychiatric disability.

Adjustment to Foster-Family Living

As a group, these men had made a "good" adjustment to family care; they were no trouble to their sponsors (foster family); followed directions; were very quiet (actually withdrawn); and had no vital interests, hobbies, or goals. They had a static quality that made them predictable and easy to care for. The sponsors seemed satisfied with this level of adjustment and expected no more. They provided simple, unimaginative activities consisting mainly of family gatherings within the home.

The patients were living in homes which had been studied and selected by the family-care social worker from the hospital. He continued, during the project, to carry responsibility for casework services to patients and sponsors. (The process of family care is conceived as rehabilitation, with medical consultation always available.) During the study project, this social worker continued his individual relationships with patients and sponsors, and conferred with the social group worker responsible for the study.

The research design for this demonstration project was a relatively simple one. Social worker and group social worker made independent records of observed changes in patients' personal responsibility, symptomatic behavior, orientation to reality, social relationships, initiative, and vocational interest. These recordings were descriptive and were done at intervals. Sponsors were asked to complete scales, rating their charges as to skill in communication and interpersonal relations; care of self and social responsibility; and satisfactory functioning in work, activities, and recreation.

Judgments on the basis of all these observations were made by the hospital social service staff—the chief,

*Mrs. Singerman was employed by the Ida S. Latz Foundation, Inc., as the social group worker in charge of patient-group activity for the social group work project.

assistant chief, and consultant in social work research. The final rating as to the positive, negative, or lack of change in the patients' apparent adjustments was based on the majority opinion of the three judges.

These ratings were compared to determine their reliability. In 74 per cent of the judgments made, there was perfect agreement among the three. In 19 per cent, there was a disparity on only one out of the six ratings for each patient. The remaining 7 per cent had four out of six ratings in agreement. The ratings, therefore, were considered reliable.

We were fortunate that the board of the foundation sustained its interest in the study and encouraged us to continue, since we encountered problems we had not anticipated. The worst difficulties arose from the resistance, hostility, and resentment of the sponsors with whom the patients lived. Although we had introduced the idea of social group work some time before starting the project, and had held a group meeting of all sponsors, the setting up of an activity group for the patients on a regular basis was a threat to the sponsors. They saw the idea as a reflection of their inability to care for patients—an indictment of their adequacy. Moreover, they had gained a certain satisfaction from the dependent, compliant patients.

Another difficulty was that the recently built Community House could not be used except at an exorbitant price. Initially, we had to hold our meetings in the recreation room of the home of one of the sponsors whose negative feelings were not quite so acute. Some families found that they could not transport their patients to the meeting place. For these reasons it took about six months for the project to settle down.

Good Working Relationships

On the positive side, there was a good working relation between the social caseworker and the social group worker. This enabled the caseworker to handle the sponsors' resistances directly with the families themselves, while the group worker confined herself to dealing with the family-patient relationships raised by the patients in the group meetings.

During the first phase of the study, which lasted about eight months, the activities were simple—preparing and serving refreshments, making mosaics and paintings, and playing quiet games of pool, checkers, chess, and shuffleboard. Verbal communication was minimal. The group worker focused on developing a relationship with each individual, helping each one to take part in some activity, and making use of every clue that one person was becoming ready to relate to one or more people in the group.

During the second phase, lasting some ten months, the men started becoming aware of one another as friends, and would greet and help one another. The emphasis now was upon developing relationships between group members. There was more group cohesion; projects were designed to involve several men simultaneously. This closer interaction led to some blow-ups and altercations, of course, but nevertheless, relationships were established which the men carried on outside

of the group meetings. They started to feel free to go to a restaurant for lunch, to a baseball game, to the theater, or to the local swimming pool. The owners and proprietors accepted them as ordinary customers. Although none of the patients exhibited bizarre or unusual behavior, the group worker always accompanied them, since there were incidents of nonpayment of bills and apparent loitering. Shopping for craft and recreation material was also a joint project with the group worker.

After eighteen months, the meeting place was changed to a public park because the men had become interested in activities which required space and large equipment. By this time, they were all known in the community, and could comfortably use commercial and public facilities. The project staff—caseworker, group worker, and caseworker supervisor—were accepted as responsible people, and permission to use the new County Recreation Building and all its facilities was endorsed by local county authorities. The facilities include a meeting room, cooking equipment, a swimming pool, outdoor ball fields, and other recreational resources.

Resocialization Accomplished

The men undertook more masculine tasks—toy-making; constructing outdoor play equipment; repairing and repainting tricycles, bicycles, and wagons; and designing and building a trailer. The men shopped for the tools, hardware, paints, and other supplies needed for their various projects, some of which had become highly complicated and called for increased skills such as working with leather, metal, and wood. They also planned for activities between group meetings.

During this phase, which was marked by recreation plans developed independently of the group worker, two of the men acquired cars and drove themselves and others to movies, the different sponsors' homes, adult education classes, and an occasional local dance. The group worker did not accompany them on all these junkets.

Now after two years, the focus of the social group work has shifted. The men take responsibility for one another on their own time, and extend a real helping hand to the new men who join the group at intervals. They have a vital group life with the usual friendships and animosities found in a "normal group." The social group worker, recognizing the group's readiness for her interpretations, encourages open informal discussion about blow-ups, arguments, and dependencies. The men look for understanding and interpretation of their own behavior, as well as the reactions of the other patients to situations which grow out of the group activities. They have become able to ask direct questions about the reasons for their own behavior. For instance, the group worker was encouraging one patient, Don, to add a mosaic handle to a piece of woodwork. Don exploded angrily, talking about things unrelated to the situation. Another patient commented, "Your personality isn't working today, Mrs. Singerman." The group worker explained that Don had a right to react because he felt he was being unduly pushed. Don seemed relieved to discover that this was understood, and the rest of the

group acquired some insight into their own reactions.

A Few Case Examples

Joe was an almost silent, compliant man who took care of his personal needs and did a few chores in the sponsor home. He is now an alert, attractive individual, skilled in mechanics, who helps new group members. He designed and built a toy cement mixer that works and is used in local nursery schools. He drives his own car and helps transport others to meetings.

John, a lobotomized patient, was conforming, but irresponsible and socially inept. Although we expected little change in John, we were surprised: he used the group to learn to get along with others, assumed responsibility, and actually became the "host" for the group. He is well known throughout the community. People have developed a real fondness for him. He takes classes in adult education and has made good friends there.

William seemed to live in a dream world; he was almost catatonic, with no interest in others, or apparently, in himself. He has "come alive." His first activity was a result of the group worker's ingenuity in providing ready cake-mixes. He takes pride in being the chief baker of the group. He has made friends, attends community activities with them, is well groomed, and converses adequately, even in French!

Alfred was somewhat withdrawn, is highly intelligent and has artistic talent; he had minimum relationships with others. His progress has been so rapid that he has been discharged, and now works in his former family-care home on real maintenance jobs. He secured his driver's license, bought a car, and transports patients to the group meetings and school.

Conclusions

Twenty-five participated in the project up to November 1959, 11 for a minimum of 12 months. The other 14 were in for shorter periods. Every man in the group of 11 improved in three or more areas of adjustment; 8 of the 14 short-term participants showed some improvement.

As a group, these 25 men moved from social isolation to developing relationships of a satisfying nature within both the group and the neighborhood. They are now contributing to society instead of "feeding on the fringes." The people in the community know these men, and look to them for help in planning joint recreational and service projects. The research findings are even more positive than we had anticipated. The full report is both descriptive and statistical, and could provide a design for similar programs.

From our research findings we are convinced that regressed schizophrenic patients can improve with consistent social-group-work service. Today, these men are, without exception, productive rather than dependent members of society. They are engaged in service to the community, such as repairing equipment and the houses where they live, and reconditioning toys used in cooperative nursery schools.

They have demonstrated real mechanical ability in the repair of their own cars and of others (four of them own an automobile and have a driver's license.) Some of them have part-time paid employment and others are slowly preparing to assume similar responsibilities. All of them have learned that adult education classes, the public libraries, and parks can offer social contacts as well as more concrete gains.

This small community has been an excellent setting for this rehabilitation project, because of the community's accepting attitudes, and the resources which have been developed. Some club groups have expressed an interest in both personal involvement and financial support. If this support develops, another group could be formed from a nucleus of the original, and offer membership to both state and Veterans Administration patients either in family-care or in their own homes.

To end on a practical note: there is today a regular flow of money into the community coffers for board and room as these men become partially self-supporting. Moreover, the increased expenditures for craft materials, clothing, recreation, and automobiles is a sizeable contribution to the merchants in this community. •

A full mimeographed report on this project with definitive research findings has been prepared by Helen Northen and Dortha M. Lane. There is an appendix by Gladys Singerman which consists of chronological reports of the group process. This is available at the Veterans Administration Center, Neuropsychiatric Hospital, Social Work Service, Los Angeles, California.

Recruiting through Education

DURING THEIR SENIOR YEAR, home economics students from San Jose State College may spend 30 hours in the food department of Agnews State Hospital, San Jose, Cal. The optional course includes 10 hours of administration (compiling food estimates, personnel management, kitchen and dining room planning, and organization); 15 hours of diet therapy; and 5 hours of dining room service. Students receive college credit for the course, and it is an excellent personnel recruiting source for the hospital.

LOUISE HICKS
Food Administrator

EDITOR'S NOTEBOOK REFERENCES Pg. 5

¹Greenblatt, Milton, and David Kantor: *Student Volunteer Movement and the Manpower Shortage*, Paper #101, 117th Annual Meeting of American Psychiatric Association, Chicago, May 12, 1961.

²Ewalt, Jack R., *Director, Joint Commission on Mental Illness and Health: Action for Mental Health, Final Report of JCMIH*, Basic Books, Inc., New York, 1961, pp. xxvi, xxvii.

THE HOSPITAL FARM



BOON



OR BANE TO PATIENTS?

THE HOSPITAL FARM might be classified as a culinary cornucopia from which all blessings flow, and, depending on the hospital involved, it also might be used as green-thumb therapy for psychiatric patients. However, for many years, our farm at the Lynchburg Training School and Hospital in Virginia needed a stopcock to stem the overflow of blessings, and our patients got a little too much dirt under their green-thumb fingernails.

On the surface, the farm was an agricultural success—its productivity was the pride of the surrounding area.

By **JOSEPH W. RISK**

Food Service Director

*Lynchburg Training School and Hospital Colony
Lynchburg, Virginia*

The dairy farm featured large, impressive barns with private stalls for cows who enjoyed the best of automatic milking equipment, individual grooming, and a diet of very select feeds.

On the produce farm, bright red tractors tilled the soil, and combines mowed and baled hay in neat rows ready for stowage in large hay barns. Tomatoes, under constant care, grew large and luscious. Beets, turnips, string and pole beans, collards, and potatoes fairly leaped out of the ground.

State-employed professional farmers, with the help

of from 40 to 60 patients, gave the farm their best during the growing and harvest seasons, and, indeed, it showed.

Tomatoes and Tomatoes and Tomatoes

Eventually, a large truck, bulging with 100 bushels of ripe, red, savory tomatoes would roll up to the hospital's main kitchen and unload. Being somewhat ambivalent toward such momentary abundance, the food manager, knowing he had 2,750 patients to feed, promptly decided to use 20 bushels for salads, another 25 for tomato soup and tomato gravy, and a few more for stewed tomatoes.

But, unfortunately, the first truck was only a signal; more and more of them arrived. Patients ate tomatoes scrambled with eggs, fried, stewed, and boiled, until most patients hoped they never saw another of these crimson delights. Yet, even when the patients were surfeited, they continued to get more tomatoes; the kitchen had to serve the ubiquitous vegetable because the food service department had to pay for raising the crop.

Then came string beans, arriving by the truckload. Women patients snapped and cleaned the beans, and the cooks prepared them as swiftly as possible, but older stock, speckled with black spots and other signs of deterioration, had to be used. Old beans lose their food value, and the danger of harmful bacteria increases. Moreover, the food manager could not afford to order a variety of foods because he was automatically charged for the deliveries from the farm, which had to show a profit. And so the deluge continued—with beets, cabbages, etc.

Luxury for Bovines

Let's explore our fine, showplace dairy barns with a little more perspective. Each cow had its own private stall—some of our patients slept on mattresses on the floor because of the lack of funds for adequate patient space and beds. Cows were bathed and groomed daily—our patients, 50 of them to every one attendant, were certainly not bathed individually every day. Milk sterilizers and pasteurizers were necessary in the barns—patient wards used dishpans and hand washed dishes. (The cost of a milk can sterilizer and a pasteurizer is much higher than the charge for installing a small automatic dishwasher that will sanitize dinnerware properly in food service areas. Moreover, unsanitary dishwashing spreads diseases much faster than raw milk from tubercular-tested cows.)

Did our farm really save the taxpayers' money? Did it help to rehabilitate patients? Less than 3 per cent of our patients benefited from the "fresh air, sunshine, and physical development" on the farm. And it is debatable whether these patients were chosen for the purpose of rehabilitation or because they could follow simple instructions. I doubt if any farmer would employ help on a 40- or 48-hour work week basis and consistently show a profit. How then could a state mental agency do it?

Realizing this, the Commonwealth of Virginia

finally decided to abolish the farm and use the funds usually spent on farm equipment, cows, pigs, and seed to provide better patient-care.

Now, our farm, as such, is gone. However, none of the professional farmers were separated from the institution; some were assigned to the ground crew and their knowledge is being used in caring for plants, flowers, and grass. Others have proved their worth in various departments of the hospital.

And the fertile fields have not been wasted. The cow barns have been converted to temporary wards for patients. Most importantly, to take advantage of the truly rehabilitative aspects of farming, we established a vocational rehabilitation gardening program. We are happy and proud to report that after two years in operation it has worked very well.

New Plans for the Good Earth

The gardening program is more rehabilitative—without the pressure of productivity—than the farm because patients learn while they work. The hospital converted a large farm storage building into a classroom and employed qualified instructors. Each day—rain or shine—the instructors teach patients the "why" of fertilization, rotation, and other important techniques of farming. They show patients proper methods of using and repairing hand tools, how to prepare and utilize insecticides, etc. Watching plants grow from seedlings to harvest and occupational activities in gardening provide therapeutic opportunities for the training of patients and the development of better work habits.

The clinical director, social service department, and nursing service decide which patients can benefit from vocational gardening. This way the program continues on a treatment-oriented basis.

This year, the garden program will be extended by adding individual garden plots. We also plan to plant a one-acre flower garden for teaching landscaping and home and garden beautification. Soon we will construct hotbeds for starting plants.

The food service department, to make practical use of garden-grown foods, prepared a fresh vegetable requirement list. Smaller fields of vegetables are planted from time to time during the best growing season. Since the supply from the garden is usually insufficient, there are never more vegetables delivered to the kitchen than it can utilize. Local vendors supply additional vegetables.

Produce and milk prices vary with supply and demand, and since most mental institutions buy on competitive bids in large quantities, they can take advantage of prices when the supply is greatest on the local market. As a result, patients get a well-balanced diet and the local taxpayers benefit because of the additional money spent in the community. Moreover the state is not in competition with the people who help to support the hospital.

In the final analysis, the "reorganization" of our farm may never be reported in the *Progressive Farmer*, but judging by where it is being published, it has accomplished its purpose. •



NEW FRONTIERS for Mental Health

By KENNETH E. APPEL, M.D.
(1953-1954)

Chairman, Department of Psychiatry
Hospital of the University of Pennsylvania
Philadelphia, Pennsylvania

THE FINAL AND SUMMARY REPORT of the Joint Commission on Mental Illness and Health, *Action for Mental Health*, was published by Basic Books last March, following the presentation of the report and recommendations to Congress last December. It was written by the Joint Commission staff on the basis of the findings of ten separate monographs, and recommended, by the Committee on Studies,¹ for adoption by Congress.

Some idea of the national importance of this book is shown by the fact that the American Legion granted funds for its official distribution throughout the nation. It is one of the most comprehensive health studies ever made. I know of no other which received a full-page discussion in the *New York Times* (March 24, 1961) and a two-column review by William Lawrence in the science section of the Sunday edition.

The summary report is a bald, stark, factual presentation of the facts and figures of mental illness. It contains challenging, practical, realistic recommendations for tackling mental illness in the United States. It is the first proposal in American history that attempts to encompass the total problem of mental illness and mental health services on a national level; it could revolutionize the public care and treatment of persons with major mental illness. The document proposes federal support for pump-priming and the tripling of state and federal appropriations for the care and treatment of mental illness within the next ten years.

Action for Mental Health is a new kind of document. It is more than just a survey and catalogue of discouraging, disturbing, and distressing conditions. It is not just a list of complaints or a diatribe against the complacencies of people. It is not filled with wishful and unrealistic fantasies for ameliorative magic. It contains a challenging and inspiring set of recommendations to be modified, discussed, and used. It includes positive,

realistic, and optimistic plans for action and attack against mental illness. It is a scientific study by experts, written in words that people can understand.

It brings new responsibilities to the community, new hope to the mentally ill and their families, and new opportunities for the federal government to open new frontiers. It offers a coordinated program to counteract the sapping of our national manpower resources through mental illness. The program, if adopted, will revolutionize the public care and treatment of our mentally ill fellow citizens.

Suggestions for Action

However, it is not sufficient to read only the final report. No summary can encompass the telling, warm, dramatic, compelling presentation of problems and recommended solutions contained in the other ten volumes—the Joint Commission monographs (see *Mental Hospitals*, April 1961, p. 13). At one time I reviewed many of the volumes involved in the complete study (three are still in preparation) and I found more than 150 concrete suggestions for action. Clearly, not all of these suggestions can be put into practice immediately by everybody, but they will inspire the reader and lift him to a new level of thinking about mental illness. These volumes, I believe, take futility, finality, and dire destiny out of mental illness.

The lag in the care of the mentally ill is discussed from new angles in the reports. They point out that lack of sympathy for and rejection of the mentally ill are reactions to the extreme forms of mental illness. Patients in this condition are irresponsible and often antagonistic toward those who wish to help them back to health; they are often frightening or repulsive, seeming to be caricatures or distortions of humanity. These attributes lead to the patients' isolation from their families and friends.

The reports discuss in some detail new ways of relating to and communicating with such patients. The use of drugs is invaluable; likewise, the provision of a new environment and contacts with people interested in the helping process—especially those who are experts in the intricate and deep processes of psychotherapy and psychoanalysis—is important.

¹Originally, *Committee on Objectives & Methods. Final membership of reorganized committee: M. Ralph Kaufman, M.D. (Chairman); M. Brewster-Smith, Ph.D. (Vice-Chairman); Walter E. Barton, M.D.; Jack R. Ewalt, M.D.; Nicholas Hobbs, Ph.D.; Miss Madeleine Lay; Mathew Ross, M.D.; Lauren H. Smith, M.D.; Mr. E. B. Whitten; Mrs. John R. Seeley, Consultant.*

Why Deprol is the first drug to use in depressions

Clinical reports indicate that many depressions can be relieved by Deprol and psychotherapy, without recourse to more hazardous drugs or EST.

Deprol relieves the patient's related anxiety, insomnia and anorexia without danger of overstimulation, thus permitting better rapport to be established sooner, and facilitating more effective treatment.

Deprol acts without undue delay. Its effect can be determined quickly. If unusual cases require additional or alternative therapy, this will be quickly discernible.

Deprol can be controlled — there is no lag period of a week or two over which drug effects continue after medication is stopped. In cases where alternative therapy may be needed, it can be started at once.

Deprol is safe — does not produce liver damage, hypotension, psychotic reactions or changes in sexual function; does not interfere with other drug therapies.

▲ Deprol ▲ benactyzine + meprobamate

Composition: Each tablet contains 1 mg. 2-diethylaminoethyl benzilate hydrochloride (benactyzine HCl) and 400 mg. meprobamate.

Supplied: Bottles of 50 light-pink, scored tablets.

Dosage: Usual starting dose is 1 tablet q.i.d. When necessary, this dose may be gradually increased up to 3 tablets q.i.d.



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Bibliography (11 clinical studies, 784 patients):

1. Alexander, L. (35 patients). Chemotherapy of depression—Use of meprobamate combined with benactyzine (2-diethylaminoethyl benzilate) hydrochloride. *J.A.M.A.* 166:1019, March 1, 1958. 2. Bateman, J. C. and Carlton, H. N. (50 patients). Meprobamate and benactyzine hydrochloride (Deprol) as adjunctive therapy for patients with advanced cancer. *Antibiotic Med. & Clin. Therapy* 6:648, Nov. 1959. 3. Bell, J. L., Tauber, H., Santy, A. and Fulito, F. (77 patients). Treatment of depressive states in office practice. *Dis. Nerv. System* 20:263, June 1959. 4. Breslin, C. (31 patients). On mental depressions. *Dis. Nerv. System* 20:142, (Section Two), May 1959. 5. London, M. E. (50 patients). Choosing the right drug for the patient. Submitted for publication, 1960. 6. McClure, C. W., Pass, P. M., Spasano, G. S., Palmer, E., Slatery, J. J., Konofal, S. H., Henken, B. S., Wood, C. A. and Ceresio, G. B. (128 patients). Treatment of depression—New techniques and therapy. *Am. Pract. & Digest Treat.* 10:1525, Sept. 1959. 7. Pennington, V. M. (135 patients). Meprobamate-benactyzine (Deprol) in the treatment of chronic brain syndrome, schizophrenia and senility. *J. Am. Geriatrics Soc.* 7:656, Aug. 1959. 8. Rickels, K. and Ewing, J. H. (35 patients). Deprol in depressive conditions. *Dis. Nerv. System* 20:364, (Section One), Aug. 1959. 9. Ruchwarger, A. (87 patients). Use of Deprol (meprobamate combined with benactyzine hydrochloride) in the office treatment of depression. *N. Am. District of Columbia* 29:430, Aug. 1959. 10. Settel, E. (52 patients). Treatment of depression in the elderly with a meprobamate-benactyzine hydrochloride combination (Deprol). *Antibiotic Med. & Clin. Therapy* 7:28, Jan. 1960. 11. Spilner, S. R. (84 patients). The care of the anxious and the depressed. Submitted for publication, 1959.

The optimism that pervades these volumes is well illustrated by the outlook for patients suffering from schizophrenia—the most prevalent mental disease and the one which has led to the accumulation of long-term patients in mental hospitals. Even without systematic treatment, there is a one-in-five chance of their "spontaneous recovery." Where proper psychological and social treatment is applied, there is a three-in-five chance; under optimum treatment conditions, the recovery rate may reach four out of five.

The studies point to community-oriented rather than hospital-oriented psychiatry. They emphasize the open-door rather than isolation and seclusion. They point to the multi-disciplinary attack in both research and treatment rather than to narrow professional approaches. Since the problem of mental illness is presented as a national, and not merely a local, county, city, or state responsibility, the study implies the mobilization of many more people and many more resources than have previously been considered possible or even advisable in dealing with the problems.

In these volumes, the forgotten people, the shamed, and the rejected receive new attention. And hope is expressed, not in vague, unformulated, wishful statements, but in recommendations which the experts believe are practical. Complex problems are not glossed over; even strong professional biases, scientific controversies, and public prejudices are ventilated. But our attention is drawn to the neglected resources, which are presented courageously and constructively in these various reports.

Emphasis on Prevention

The problem of prevention is discussed boldly. Many destructive processes, it is believed, can be reversed—in the school, the home, the general hospital, the community clinic, the church, or the office of the marriage counselor. Even long-term chronic patients often can be restored to the community through the help of interested and well-trained volunteers. The report cites as an example the Harvard-Radcliffe experiment at the Metropolitan State Hospital, Mass. Even more important are collaborating personnel such as psychologists, social workers, nurses, educators, clergy, and relatives, as demonstrated by Fritz Midelfort of the Gunderson Clinic in Wisconsin. New possibilities can be seen to utilize all of these people under proper psychiatric supervision. In short, new environments and new attitudes toward the mentally ill offer new opportunities which have not been considered seriously until now.

The complete study is most comprehensive, but because of the nature of the problems is by no means exhaustive. Mental illness involves many complexities—biological, chemical, psychological, and social. Much is still unknown about it. Thus, no attempt has been made to present definitive, universally approved recommendations and conclusions.

As President of the Joint Commission on Mental Illness and Health, I cannot forebear adding a personal comment. It has thrilled and inspired me to work with a group of scientists, including my fellow-psychiatrists, and with scholars from the fields of social science—both

applied and theoretical—toward the prevention and alleviation of suffering and the development of constructive resources in human beings and society. The contribution of time, energy, and wisdom by the various commissions and by members of the staff has been gratifying, and it would be ungracious and unfair to single out special contributions.

Suffice it to say that the recommendations which the Joint Commission presumed to make are bold and challenging; the study, carried out by experts from various fields, has been thorough and conscientious. It remains for us all—leaders in the mental health fields, legislators, and society at large to select for action those recommendations that seem most urgent and immediately practicable, and to press for the realization of the others when resources make their implementation possible. •

Social Security Disability Benefits for Emotional Disorders

MENTAL AND EMOTIONAL DISORDERS, as defined by the 1955 revision of the International Classification of Diseases, accounted for about 11 per cent of the workers—19,743 out of 178,952—who were found to be disabled under the social security disability program in 1959, the latest year for which figures are available. Mental illness accounted for the third largest proportion of disability determinations made in 1959. Over one-half of these mentally and emotionally disabled workers were under age 50. In contrast, only one-sixth of all disabled workers were in this age group. About two thirds (13,062) of these workers were confined to an institution at the time an application was filed under the social security disability provisions.

Monthly benefits under the social security disability program are now payable to disabled workers under 65 and their dependents. Disabled dependent sons and daughters, age 18 or over, of retired or disabled-worker beneficiaries and of deceased insured workers are paid monthly benefits if they have been disabled since before they reached 18 years of age.

In order to be eligible for disability benefits, the worker must have been covered by social security for at least five years out of the ten just before his disability began, must have had his impairment for six months or more and, because of it, be unable to do any substantial gainful work. In addition, the impairment must be a physical or mental condition that will show up in medical examinations and tests.

Today approximately 880,000 persons—disabled workers; their dependents; and disabled sons and daughters of disabled, deceased, or retired worker beneficiaries—are receiving about \$58 million each month in benefits.

DALE KLOAK
Information Specialist
Social Security Administration
Department of Health, Education
and Welfare

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13th MENTAL HOSPITAL INSTITUTE

Sheraton-Fontenelle Hotel, Omaha, Nebraska, October 16-19, 1961

Preliminary Program Topics and Leaders

SUNDAY and MONDAY, OCTOBER 15 and 16

Other Professional Meetings to be Announced

TUESDAY, OCTOBER 17

8:30 a.m.—PLENARY SESSION

Keynote Address on Main Theme of Institute

New Perspectives on Mental Patient Care: A Consideration of ACTION FOR MENTAL HEALTH, the Final Report of the Joint Commission on Mental Illness and Health

Jack R. Ewalt, M.D., Boston, Mass.
Director, Joint Commission

9:30 a.m.—PLENARY SESSION

Outline of Tuesday's Special Topic

The FINDINGS of the Joint Commission on Mental Illness and Health

10:30 a.m.-12:30 p.m.

The participants will divide into 20 groups—5 groups of approximately 40-50 people each, and 15 with approximately 15-20 each. Each discussion group will be given a specific subtopic related to the findings of the Joint Commission, and will be required to prepare a written report. The subtopics and group leaders are: *Nonmedical Care*—to be announced; *Major Mental Illness*—Henry Brill, M.D., N. Y.; Robert C. Hunt, M.D., N. Y.; Otto Von Mering, Ph.D., Pa.; *Emergency Services and Secondary Prevention*—John Cumming, M.D., N. Y.; *Psychiatric Units in General Hospitals*—Annie Laurie Crawford, R.N., Fla.; Lauren H. Smith, M. D., Pa.; T. Glyne Williams, M. D., Okla.; *Private Psychiatric Hospitals and Intensive Treatment Centers*—Thomas L. Rafferty, M.D., La.; Robert S. Garber, M.D., N. J.; Marvin L. Adland, M.D., Wash., D. C.; *Mental Health Clinics and Private Patient Care*—T. P. Krush, M.D., Neb.; *Care of Chronic Mental Cases, including Seniles*—William S. Hall, M.D., S. C.; Joseph B. Bounds, M.D., Va.; Isaac N. Wolfson, M.D., N. Y.; *Aftercare, Intermediate Care, and Rehabilitation*—T. A. Bravos, Cal.; A. P. Bay, M.D., Kan.; Walter Fox, M.D., Ky.; *Public Information*—Lucy D. Ozarin, M.D., Mo.; *Research*—Paul Hoch, M. D., N. Y.

2:00-4:00 p.m.

Simultaneous Sessions

Sessions open to all participants (free selection)

1. *The Community Responsibilities of the Hospital Social Worker.* Mrs. Ruth I. Knee, Bethesda, Md., Discussion Leader.
2. *Evaluation of Therapeutic and Operational Efficiency of the 50- to 250-Bed Hospital.* Edward G. Billings, M.D., Denver, Colo., Discussion Leader.
3. *Role of the Mental Hospital in Disaster Planning.* Panel: Chairman, Edward J. Kollar, Jr., M.D.; Hymen E. Cohen, Ph.D.; Calvin S. Drayer, M.D.; James E. Gilbert, M.D.; George W. Jackson, M.D.; C. J. Wagner, M.D.
4. *The Problems in Public Relations Surrounding Changing Programs in Mental Health.* Wilfred Bloomberg, M.D., Hartford, Conn., Discussion Leader.
5. *Open Staffs in Psychiatric Hospitals.* Ralph Meng, M.D., Sykesville, Md., Discussion Leader.

6. *The Role of Accounting in Program Development.* Mr. James C. Hodges, Lansing, Mich., Discussion Leader.

WEDNESDAY, OCTOBER 18

9:00 a.m.—PLENARY SESSION

Outline of Wednesday's Special Topic

The RECOMMENDATIONS of the Joint Commission on Mental Illness and Health

9:30 a.m.-12 Noon and 1:30 p.m.-4:30 p.m.

Group Discussions

The participants will divide into groups as on Tuesday and consider the recommendations related to their subtopic.

6:30 p.m.

Cocktail Party, Annual Dinner

Presentation of the 1961 Mental Hospital Services Achievement Awards. Presentation of Remotivation Pins. Presidential Address by Walter E. Barton, M.D.

THURSDAY, OCTOBER 19

9:00 a.m.—PLENARY SESSION

Academic Lecture

Topic and Lecturer to be Announced

10:15 a.m.-12:30 p.m.—PLENARY SESSION

Summation of Group Discussions

The group discussions will be summed up in three parts as follows:

- (A) *Nonmedical Care; Aftercare, Intermediate Care, and Rehabilitation; Public Information; Research.*
Summator: Henry W. Brosin, M.D., Pittsburgh, Pa.
- (B) *Emergency Services and Secondary Prevention; Psychiatric Units in General Hospitals; Mental Health Clinics and Private Patients.*
Summator: George Saslow, M.D., Portland, Ore.
- (C) *Major Mental Illness; Care of Chronic Patients, including Seniles; Private Psychiatric Hospitals and Intensive Treatment Centers.*
Summator: Francis J. Gerty, M.D., Chicago, Ill.

Open Discussion

2:00-4:00 p.m.—PLENARY SESSION

Panel

Federal-State Relations—Formulae for Sharing Costs.
Moderator: Mathew Ross, M.D. Panel: Daniel Blain, M.D.; Irving J. Cohen, M.D.; Mr. Sidney Spector; others to be announced.

PROGRAM COMMITTEE

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Mr. Joseph Greco, St. Louis, Mo.
John P. Lambert, M.D., Katonah, N. Y.

ABSTRACTS from Papers Presented at the 117th A.P.A. Annual Meeting

A number of scientific papers of special interest to all mental hospital personnel were read at the 117th Annual Meeting of the American Psychiatric Association, May 8-12, 1961, Chicago, Illinois. The outlines of some of these papers, published here for the benefit of the many people who could not attend the Annual Meeting, are based on the authors' summaries.

"Papers On Clinical Psychiatry." Chairman: Malcolm J. Farrell, M.D.

A Neglected Document—the Medical Record of the State Psychiatric Hospital Patient (Paper #16)

APPROXIMATELY 17,000 hospital medical records were analyzed at the Spring Grove State Hospital, Catonsville, Md. They were voluminous, loosely organized, contained much reduplication, displayed sporadic lacks of essential data, and bore a weed-like growth of outdated, irrelevant material.

A series of meetings and investigations concerning the records was initiated, and the heads of the various hospital departments became thoroughly acquainted with the problems involved. The medical records department was reorganized and centralized; its functions and lines of authority and responsibility were outlined. Nonmedical record functions were removed and more effective communications with other departments established.

A dictating-recording system, tied into the telephone service, was established to expedite data reporting. Weekend and evening coverage was initiated to reduce a chronic backlog of work which had been a drag on the system. Modern devices were introduced, such as open-shelf files, an addressograph system, a cardex visible file system for maintaining doctors' orders and nursing notes on the wards, photocopy machines, a microfilm reader and printer, sort-all alphabetizers for loose material, and a new admission packet which included all essential information for various hospital departments and community agencies. These measures saved time and reduced the volume of records.

All medical record forms were reviewed; many were eliminated and some were revised. A uniform method for filing material in medical records and a detailed policy for releasing information from them were adopted.

Quantitative and qualitative analyses of patients' records are being initiated. They will make medical

audits more effective, and, ultimately, will be an aid in developing more sophisticated information-retrieval systems.

This study emphasized again and again that there are no substitutes for an adequately subsidized and maintained up-to-date medical records system. To achieve this, the medical records department cannot remain static. It must be directed by a capable department head and improve its personnel, techniques, and equipment to keep pace with the increasing complexity and demands of the various clinical and administrative services essential to better patient-care.

BRUNO RADAUSKAS, M.D., *Superintendent, Spring Grove State Hospital, Catonsville, Md.*; ALBERT A. KURLAND, M.D., *Director of Research, Department of Mental Hygiene for the State of Maryland, Baltimore*; and SIDNEY GOLDIN, B.S., *Executive Director, Medical Record Project, School of Hospital Administration, Richmond, Va.*
Discussant: FRANCIS J. O'NEILL, M.D.

• • •

"Papers On Social Psychiatry." Chairman: Robert T. Morse, M.D.

A Program of "Pre-Vocational" Preparation and Evaluation for Patients of a State Department of Mental Hygiene (Paper #25)

SUCCESSFUL VOCATIONAL FUNCTIONING is completely accepted as a measure of personal adequacy in our culture. However, many members of professional disciplines believe that a former mental patient's vocational capacity is limited greatly because of the nature of his illness.

A four-year study of some 450-500 post-hospitalized patients who had been referred to the vocational consultant as constituting "vocational problems," revealed among other things that: (a) the productive capacity of the former hospitalized patients exceeded, by far, previous estimates; almost one half of them were deemed capable of economic productivity, and the predictability

for subsequent vocational adjustment was found to be better than 80 per cent accurate; (b) previously utilized criteria such as diagnosis, chronicity, and length of hospitalization were not the major determinants for success or failure of vocational adjustment. Instead, the major determinants were found to be the motivation of the patient, his ability to translate thought into action, and, above all, his readiness to participate in both vocational planning and implementation of the plan.

The findings of this project indicated that, in the community, vocational problems of post-hospitalized mental patients were compounded not only by their illness, but also by their general lack of preparation to meet the requirements for competitive employment and economic participation. More than half of the patients had not graduated from high school. Even those who had formal education beyond high school had participated in various liberal arts curricula having little or no direct application to the requirements of making a living. Of the total group, only 2 per cent had any formal vocational or business training. These patients had to overcome their lack of specific skills as well as problems radiating from limitations imposed by their mental illness, or by employer resistance resulting from the "stigma" of mental illness.

These findings are significant in a society where technological development has been decreasing the number of unskilled and semiskilled jobs and where high

school graduation already constitutes a bare minimum for employment. They are even more significant when we consider that the study's subjects reflect a cross-section of the working population. A majority of the patients were from 22 to 50 years of age, a time of life culturally defined as the economically "productive years." Therefore, successful vocational adjustment was important for these patients.

The finding of the lack of readiness for employment is considered to be a positive one. It revealed how an unprepared patient's search for employment could only result in failure and, thus, additional stress, and emphasized the need for preparing him more adequately to make more effective use of available agencies and facilities.

The findings of this project encourage the belief that there is both a *need* and a *place* for a vocational specialist on the psychiatric team. This addition to the staff would enable former hospital patients to make a more complete and effective reintegration into the community.

GERALD KISSIN, M.A., *Director of Rehabilitation, Mental Health Association, Nassau County, N.Y.*; DONALD M. CARMICHAEL, M.D., *Director, New York City Aftercare Clinics, New York State Department of Mental Hygiene, New York, N.Y.* Discussant: BENJAMIN PASAMANICK, M.D.

• • •

"Papers On History." Chairman: J. Sanbourne Bockoven, M.D.

"Moral Insanity" in the United States, 1801-1868 (Paper #61)

THE CONCEPT of "moral insanity"—mental illness with little or no observable disorder of the intellect—was first described by Philippe Pinel in 1801, and elaborated in 1835 by James Cowles Prichard. This idea is significant in psychiatric history because it led to the concepts of neurotic character, psychopathic personality, and affective disorder.

Contrary to the opinions of most psychiatric historians, a large number of leading pre-Civil War American psychiatrists accepted the concept of moral insanity, as had their predecessor, Benjamin Rush. These men also stressed the psychological element in the etiology, pathology, and treatment of mental illness and were in advance of their colleagues on most psychiatric questions. They asserted that medicine—rather than philosophy, religion, law, or public prejudice—should define mental illness, and insisted that medical findings be judged by the criteria of scientific truth and clinical experience, not by moral precepts. Many psychiatrists, however, disagreed with these proposals, and, reluctant to flout conventional lay opinion by taking an unorthodox stand on this or other sensitive issues, rejected the concept of moral insanity on theological, philosophical, or legal grounds. The increasing emphasis, both in general medicine and in psychiatry, on local pathological anatomy strengthened their opposition, but controversy

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centered mainly about the nonmedical implications of the theory. By 1868 the more orthodox psychiatrists had won out, and only a few individuals still maintained a belief in moral insanity as a type of mental illness.

NORMAN DAIN, M.A., *Research Assistant, Department of Psychiatry*; and ERIC T. CARLSON, M.D., *Assistant Professor of Clinical Psychiatry, Cornell University Medical College, New York, N.Y.* Discussant: IAGO GALDSTON, M.D.

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"Section On Private Practice of Psychiatry." Chairman: Paul H. Wilcox, M.D.

The Care of Psychiatric Patients in a General Hospital without Special Facilities (Paper #80)

FROM 1954 to 1958 the number of community general hospitals in the United States accepting psychiatric patients increased by 40 per cent. By 1958 the number of psychiatric admissions to community general hospitals was larger than the number of admissions to public mental hospitals. This paper reports how a small community general hospital used established facilities (carefully avoiding the addition of separate ones) to admit and care for psychiatric cases.

Psychiatric patients were admitted to all floors and to all patient-accommodations within the hospital. They were not segregated in any way and shared multiple-room accommodations with medical and surgical cases. Floor-duty nurses provided nursing care. The management, treatment, and study of psychiatric cases conformed to the same practices used on all other patients in the hospital.

Experience over a three-year period demonstrates that a general hospital, using facilities that ordinarily exist for the care of patients with physical disease, can admit and successfully treat a wide variety of psychiatric disorders.

As might be expected, problems and limitations arise in a program of this nature, one of the more serious being that in the patients' areas there are no suitable rooms for conducting psychotherapy. Such facilities are most urgently needed on general hospital floors having multiple patient-accommodations. By-and-large, psychiatric patients are physically well, and since they are not confined to a bed, the problem also arises of how to fill their daytime hours.

General hospital care for the psychiatric patient has the advantage of permitting him to be treated in his own community. As a result, both the patient and his family accept his hospitalization more readily. Usually, his health insurance plan provides some coverage for such care, although the cost of care in a mental hospital may be excluded. General hospital care permits patients to have simultaneous psychiatric, medical, and surgical study, since almost always several physicians are involved in each patient's treatment. In addition, the program is of educational value to members of the staff, interns, residents, nurses, and student nurses.

This method of approach to the care of psychiatric

patients in a community general hospital is recommended to others who are considering similar programs.

PAUL W. DALE, M.D., *Associate Attending*; and HAROLD S. WRIGHT, M.D., *Director, Department of Psychiatry, Greenwich Hospital, Greenwich, Conn.* Discussant: EDWARD G. BILLINGS, M.D.

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"Papers On Hospital Psychiatry." Chairman: Joseph E. Barrett, M.D.

Training in Social Psychiatry at Ward Level (Paper #98)

THE ROLE of the ward doctor is becoming more complex because of increased interest in the patient's social environment. It is not enough for him to be a competent diagnostician and individual therapist; he must now learn to recognize and modify the social organization and culture of his ward as well as to master the complexities of group treatment. He must learn to integrate the contributions of colleagues in other professions—psychologists, social workers, nurses, and possibly social scientists—as well as patients. To do this adequately, he must be conversant with the skills and personalities of his colleagues and able to help them find their optimal role at ward level.

The various role-relationships may present serious problems and call for a mixture of psychiatric, administrative, group dynamic, and social science skills. The final responsibility for patient-management still rests with the doctor, but it is debatable whether the psychiatrist, with his present training, is competent to play this complex role of ward leader. Considerably more training in group dynamics and social science is probably necessary for the doctor to make optimal use of his staff and the social environment. Such training is invaluable preparation for future mental hospital administrators. This development appears to be central to the creation of a psychiatric practice geared to the needs of mental health services rather than being predominantly a preparation for private practice.

Nevertheless, the future private practitioner also would benefit from such experience during his psychiatric residency. If, as seems probable, the tendency will be for more and more patients to be treated in the community rather than in the hospital, then clearly their supervision will be the concern, in part at least, of the private practitioner. These patients will, in the main, present a psychotic picture; their management will require the utilization of social welfare, the general practitioner, and family care, integrated in a way which has much in common with the practice of social psychiatry at ward level.

Finally, for such training to be really effective, it will be necessary for residency training programs, both in medical schools and in state hospitals, to have intra- and extramural practice of psychiatry for this to develop.

MAXWELL JONES, M.D., *Director of Education and Research, Oregon State Hospital, Salem, Ore.* Discussant: ALFRED H. STANTON, M.D.

CONTEMPORARY COMMENT

Editor's Note: The unceasing struggle for better treatment of mental illness—to steal a cliché from our State Department speech writers—is literally “a battle for men's minds.” In this battle, the weapons are, for the most part, words: words addressed to the public, spoken to our patients, and exchanged between one another.

No words today are more contemporary than those written in the ten monographs and final report of the Joint Commission on Mental Illness and Health. Some of the words from the published reports* are quoted here, in the hope that our readers will be tempted to reach for the full texts and contribute, in turn, their own words toward the acceptance or rejection, the implementation or abandonment of the findings and recommendations of the Joint Commission on Mental Illness and Health.

From: Epidemiology and Mental Illness

“The mental health of the individual depends on his ability to make the adjustments consistent with social living, at the same time preserving the integrity of his personality. If social scientists will forgive a simple metaphor, we might say that the personality is the imperfect dike constructed from heritage and environment that must hold back the waters of anxiety, frustration, and guilt, whatever their source. Groups and populations, too, have their personality dikes, as witness the retention of the customs of the old country by minority groups, the protective regulations of professional associations, fraternal organizations, and labor unions, and the determination with which the southern states oppose racial integration. . . .

“It is the task of epidemiology to define the size and content of this vast problem (mental illness). Clinical and experimental weapons have only made a dent on that small segment of the problem which annually comes to the attention of the treatment facilities of society; yet, it is unthinkable that the scientist should refrain from directing a coordinated attack on mass mental illness until knowledge of its origin and course in the individual is on a par with that of the communicable diseases.”

RICHARD J. PLUNKETT, M.D.
Associate Director, Joint Commission
on Mental Illness and Health
JOHN E. GORDON, M.D.
Harvard School of Public Health

*All reports are published by Basic Books, Inc., New York.

From: Current Concepts of Positive Mental Health

“Definitions of mental health to some extent must be matters of convenience. A definition in itself solves no problems and does not add to knowledge; all that can be expected from it is usefulness in achieving the purposes of science. Yet, . . . there are many efforts to define mental health in ways that go far beyond this scientific approach to definition. They often contain implicitly personal or general philosophies—they often specify how human beings ought to be. Such ‘definitions’ . . . have to be examined.”

MARIE JAHODA, Ph.D.
Brunel College of Technology
England

From: Community Resources in Mental Health

“ . . . The initiative for the creation and development and coordination of mental health resources in communities rests foursquare with the mental health leadership. It is up to them to show the way. And in the process of helping to develop these resources, they will have to recognize and learn to live with their reliance on many other individuals who, by the force of circumstances, are involved in the treatment of mental and emotional disturbances. . . .

“ . . . it is not enough for consultants and field staff responding to needs for help in local communities to be able to advise on specifics, such as the organization of clinical services, or of nursing services for patients, or of pupil personnel services in the schools. Such consultation in depth is essential, of course, but provision must be made as well for staff persons able to consult and advise local communities on planning and development of the whole range of mental health resources. . . . Perhaps, . . . we can recruit more staff with community organization insights and experience who can gain understanding of the specific issues in developing mental health resources. . . .

“ . . . A community program for mental health must be a cooperative effort, seeking to strengthen all the resources involved.

“Mental health interests, therefore, should ally themselves with those now working for better service in such fields as public welfare, pupil personnel, probation, child welfare, public health, and recreation. Support for these

fields, combined with the development of hospital and clinical service, would insure a balanced mental health program giving proper weight to prevention."

REGINALD ROBINSON, Ph.D.
Massachusetts Committee on Children
and Youth

DAVID F. DEMARCHE, Ph.D.
United Community Fund
San Francisco, California

MILDRED K. WAGLE, M.S.S.A.
Child Welfare League of America

From: Americans View Their Mental Health

"The shortage of trained mental health personnel works totally against the purposes of mental health education. Increased mental health education only serves to tax already inadequate mental health services. Inasmuch as present services tend to gravitate toward the best informed, it would appear that the psychologically rich get richer and the poor get poorer. . . .

"As the education level of the general population increases, and as the growing acceptance of psychiatry now evidenced in the younger generation becomes characteristic of the total culture, we should expect the demand for therapeutic facilities to increase. . . .

"We hope that this study will help to clarify the kinds of factors that operate in determining whether or not a person in need of help will use the opportunities available to him. We hope, even more strongly, that it contributes to the formulation of programs designed to make such help available to the maximum number of people in trouble."

GERALD GURIN, Ph.D.
JOSEPH VEROFF, Ph.D.
SHEILA FELD, Ph.D.
University of Michigan

From: Mental Health Manpower Trends

"... we must recognize that the physician not specially trained in psychiatry—the general practitioner, the internist, the pediatrician, among others—is occupied frequently with the care of emotional problems. The support and reassurance of the understanding physician is of crucial importance in the mental health of large numbers of our citizens. . . .

"We would be unrealistic to pin our hopes on research breakthroughs in the future, or on rapid changes in the patterns of patient care, as the mechanisms through which manpower shortages in the mental health professions are likely soon to be eased. New treatment techniques discovered, and more effective patterns of patient care, usually require more trained personnel

rather than fewer. . . .

"What we need are techniques and methods enabling far more people to be reached per professional person. If we do not at present have such techniques, then we should spend time looking for them. The logic of the manpower situation in which we find ourselves makes other solutions unrealistic."

GEORGE W. ALBEE, Ph.D.
Western Reserve University

From: Economics of Mental Illness

"... public institutions must remember the purposes for which they were set up and . . . should not congratulate themselves and feel that they are accomplishing these purposes merely because they do not make a profit. Economic and budgetary problems and principles are, therefore, not the only guiding principles for the institutions that society has established for the ultimate purpose of supporting, caring for, and advancing the members of that society and the society itself. . . .

"The final question that we must discuss is: 'What can society afford to spend on mental illness?' Many of our earlier remarks have suggested the kinds of economic considerations that should be involved in an answer (by society) to the question, 'What should society spend on mental illness?' The economist cannot answer the first question. . . .

"Our data suggest that the problem of mental illness is significant enough so that the question might well be put: 'What can society afford not to spend on mental illness and health?' We can do nothing; we can do much. Our value system will decide which course we choose. The economic data raise the question whether we dare do nothing."

RASHI FEIN, Ph.D.
University of North Carolina

From: Action for Mental Health

"If we are to accelerate the mental health movement, reduce mental illness, and improve mental health, we must rise above our self-preservative functions as members of different professions and different social classes and adherents of different economic philosophies and illuminate the means of working together out of mutual respect for our fellow man. We each have our roles and our sense of duties and obligations, but also we each have one kind of responsibility that is common to all and transcends all others. This is our responsibility as citizens of a democratic nation founded out of faith in the uniqueness, integrity, and dignity of human life."

JACK R. EWALT, M.D.
Director, Joint Commission on
Mental Illness and Health



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*Ayd, Frank J., Jr.: Drug-induced Extrapyramidal Reactions: Their Clinical Manifestations and Treatment with Akineton. *Psychosomatics* 1:143 (May-June) 1960.



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The sixth green of the employee-operated golf course nestles beside the Hudson River in the shadow of the rolling Catskill Mountains.

"FORE" AFTER FIVE

By FRANCIS K. STEEVES

Chaplain

Hudson River State Hospital

Poughkeepsie, N. Y.

ANOTHER SEASON is in full swing on the beautiful nine-hole employees' golf course at Hudson River State Hospital in New York—during off-duty hours, naturally. This year the course should test the skills of more golfers—hospital employees, patients, and friends in the community—than it has since its first two fairways were carved out of a cornfield in the 30's.

The course, operated and financed since 1937 by the employees' Golf Association through annual fees from its 400 members, has grown steadily to a near-capacity business. The association consists primarily of hospital employees and their families whose membership dues are \$10. A limited number of non-employee memberships are available by invitation at \$20, and a few complimentary mem-

berships go to officials of neighboring municipal and state agencies.

The course serves various functions in the life of the hospital, and rates high among employee fringe benefits. Aside from the opportunity of free play it offers association members, and its obvious value as a boon to relaxation and recreation, the course promotes intra- and inter-hospital relationships. A variety of tournaments bring staff members and other hospital workers together, facilitating closer friendships among the employees, their families, and community leaders.

Two matches are played annually with employees of three other hospitals under the New York Mental Hygiene Department; friendships are made which lead indirectly to a



A golfer, under the scrutiny of his competitors, swings hopefully toward the ninth hole.

The inviting club house was built with funds raised by gala days and exhibition matches.



broader perspective of state hospital operations. The success of the outings has resulted in plans to include more hospitals in future matches.

The club's value in making friends in the community is attested to by the recently established Nathan Reiffer Trophy. This influential business man of Poughkeepsie, as a member of the club, often contributed time and materials to the course, and members wanted to memorialize him. As further evidence of community good

will, area Jaycees recently initiated an annual tournament with patients, offering trophies and prizes to patient-winners.

One of the most important values of the course lies in its benefits to patients. Each year the association employs seven or more patients to maintain the course under the direction of a groundsman who is a golf professional. Some of these patients, once confined to disturbed wards, who were given permission to work with

the golf crew, have improved enough to be discharged. Moreover, the regular income proves helpful to patients without family or financial resources.

The caddie master, a patient, cares for the club house and supervises the 21 patient-caddies. He supplements his income by polishing the members' clubs and shoes. Caddies take advantage of quiet periods during the day to sharpen up their own games.

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Samples and literature available on request



Mount Vernon, New York

Tournaments and Trophies

There is an annual caddie tournament and a caddie-member team tournament. One of the trophies is a memorial named for a favorite caddie of recent years. The trophies are awarded at the close of the season when the caddies are entertained at a banquet held in one of the city's clubs. An orchestra plays for dancing, and ladies of the association serve as hostesses for this occasion, which is a highlight of each year, particularly for patients who have been hospitalized a long time.

Golf instruction, under the direction of the recreation department, is given to patients upon prescription by their doctors. Last year 40 men and 35 women received lessons. After patients demonstrate sufficient skill, free play cards are issued by the physician to those who would benefit most from golf.

One hundred and seventeen patients participated in the club's activities last year, including the Ringers Tournament, Jaycee-Patient Tournament, Championship Tournament, Inter-Hospital Matches with neighboring Harlem Valley State Hospital, as well as the qualifying rounds for each tournament.

Patients also receive annual contributions of recreational items—television sets, a high fidelity set with records, ping-pong tables, lawn settee swings, typewriters, and golf clubs—bought with funds from the club treasury.

The course has won a secure place in hospital life. Credit is due the directors of the hospital, who have provided active support and counsel, but the real worth of the club derives from the fact that it is employee-inspired and employee-operated. •

Personalization of Patient Care

in a Mental Hospital

By ERNEST P. NEWCOMB
 Chief, Nursing Service
 VA Hospital
 Fort Lyon, Colorado

THE AUTHOR returned to nursing in a mental hospital in 1956, after a 10-year period in general nursing, and was pleased to witness the commendable improvements that had occurred in the interim. Patients were wearing their own clothing instead of drab hospital garments, and their living, recreational, and dining areas were tastefully decorated. However, personalized patient-care had not progressed commensurately during this interval.

A guard-like attitude was manifest in all patient-nursing assistant contacts; the emphasis was on prevention of elopement, suicide, and assaultive behavior. Control measures were observed in the dining room and day rooms; during variety shows, ball games, therapeutic exercise walks; and even in the most relaxed situations, such as sitting on the lawn or viewing motion pictures on the wards. This rigid custodial attitude prevailed in the various clinical activities as well. Often, patients were given attention only if they were well enough to seek it.

Analysis of the nursing-care structure revealed that nursing assistants were assigned to wards without designated patients to care for. An average of four nursing assistants were responsible for meeting the general needs of from 40 to 50 patients. Their duties involved environmental hygiene, preventive measures as described above, and escorting patients to activities. Otherwise, their assignments were indefinite, and interaction with patients was not stressed. Their responses to questions about patients' conditions and reactions were evasive, or they transferred responsibility to other nursing assistants on the ward. The nursing assistants actually did not know how to establish and maintain patient interaction; they seemed to fear that if they assumed responsibility or displayed initiative they would be ridiculed by their colleagues for being "show-offs" or for attempting to curry the supervisors' favor.

An exception to this nonspecific type of patient-care was ward 5C, a medical and surgical unit where assignments were more personalized. Here, each nursing assistant provided care for a limited number of patients. Patients who were transferred to this ward from the acute intensive treatment building often demonstrated spontaneous improvement in behavior. They became more sociable and less assaultive, and appeared to be more content on this ward. We could not positively

determine reasons for these changes, but the personalized care given to patients by nursing assistants evidently contributed to improvement.

We discussed with management, head nurses, and ward personnel the feasibility of introducing a similar assignment plan on the acute-intensive and the continued-treatment wards. We considered the possible advantages and disadvantages—a speculative consideration since actual results could not be determined unless the plan was given a trial.

The Pros and Cons

Advocates envisioned many benefits for both the patients and the nursing personnel. Each patient would be assured at least a minimum of interaction with personnel; he would no longer have to seek out a nursing assistant to answer his questions. The nursing assistant's choice of selection for interaction would be reduced from 40 or 50 patients to 10 or 12, and he would be able to learn much more about his patients. Mutual participation by nursing assistants and patients in various activities such as sports, woodwork, metalwork, and art would give them common experiences to discuss. The nursing assistant, having a defined responsibility, would take more interest in the personal appearance and progress of the patients. The freedom of movement in a small group would lessen the stigma associated with locked wards since checking patients by name, as is done in large groups, would not be necessary.

Opponents envisioned considerable difficulty in coordinating such a program. They doubted that nursing assistants could adjust to this more personalized type of care, and feared the assistants would feel insecure and not understand what they were expected to do. The frequency of interward transfers might interrupt group cohesion. With only one nursing assistant to control them, patients might elope.

Nevertheless, we decided to take the calculated risk and initiate the program on ward 5B, a continued-treatment locked ward with 85 patients, 15 of whom were on privilege at the time. The Physical Medicine and Rehabilitation Services Coordinating Committee modified schedules so that the small groups could attend regular activities. Nursing assistants selected patients for their groups, and in January 1957, the program began.

A critique at the end of the first week revealed that some of the anticipated negative factors had materialized. The ward physician and head nurse were alarmed because the nursing assistants were unsure of their roles, and the female nursing assistants were afraid that the patients might become emotionally involved with them. There was definite apprehension about the responsibility for elopements. Some patients not chosen for groups had become hostile and aggressive.

We recommended that the physician and head nurse review the roster of patients and make reassignments so that every patient would have group membership. Ward personnel were advised that administrative support

would be given to them if patients eloped from a small group, or if emotional involvements occurred. The recommendations were carried out, and the program continued in operation without any major adverse incidents.

Coordinated Therapy Programs

Coincident with the nursing service's formulation of the small group plan, the psychology service was developing a group therapy program in which nursing assistants would act as coleaders. The planners hoped that introducing nursing assistants into this type of program would elevate their prestige and enhance their authority in providing nursing care to mental patients at the ward level. These two projects were combined at our suggestion, and in early February the small groups began weekly discussion periods under the direction of the psychology service. Nursing assistants were leaders for these meetings. Each leader and the patients in his group met with the psychology service once a week. In addition, group leaders met together each week to discuss mutual problems, reactions to patients, and general items of interest concerning ward operations.

Achieved Goals

After six months, all personnel directly involved met to evaluate the program. Several of the anticipated gains materialized. Nursing assistants now discussed therapy rather than control, and were more aware of the patients' behavior. Evaluations prepared by the corrective and the recreational therapy departments indicated that patient participation had improved considerably. The more withdrawn patients were commencing to socialize. During the six-month period there were no elopements from small groups and transfers from 5B to the maximum security ward decreased. The number of patients on privilege increased from 15 to 47. Nursing personnel morale showed definite improvement, and nurses requested that the program be continued on their unit; they believed it was good for the patients as well as for themselves.

As a result of a comprehensive review of the benefits, this type of care-program is currently being extended throughout other nursing units. A copy of the full study of the program can be obtained upon request from H. J. Madsen, M.D., Manager, VA Hospital, Fort Lyon, Colo.

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1. Morrison, J. E.: *Hospitals* 33:97 (July 16) 1959.

2. Laitner, W.: *Psychiat. Quart. Suppl.* II 29:190, 1955.

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REVIEWS & COMMENTARY

READERS' FORUM

Everybody in the Act

THE CENTRAL OFFICE of the California Department of Mental Hygiene at Sacramento employs 250 persons, including top administrative personnel and large groups of people working in the Bureau of Patients Accounts, the Statistical Division, the Central Accounting Office, and other divisions. Recently, it occurred to me that most of these people knew very little about the scope of the Department's work.

Borrowing the idea from a general practitioner who teaches a secretarial class about the technical aspects of medical practice, I arranged to give an informal talk about the different diseases which make up the "disorders of the psychobiologic unit," illustrating the talk with colored photographs and slides. Some 150 to 175 members of our staff attended voluntarily and listened attentively, sitting on the edges of desks and in office chairs. Comments indicated that those attending considered the occasion a pleasant interlude in the day's work. The talk gave our men and women something they had not had before—technical information about the total program in which they played a small and often isolated part.

Now the Department allows work time for similar illustrated talks once a month, immediately before the lunch hour. The meetings are popular, and much discussion takes place between speaker and audience.

Other topics in the program were suggested by a committee and included: types, symptoms, and treatment of various diseases; the various forms of mental derangement; the use of hypnosis in mental illness; commitment procedures; the therapeutic community; community resources for mental health; mental diseases among children; the work of other state departments (corrections, youth authority, education) related to the

treatment of mental patients; mental retardation; and many other subjects.

Perhaps other state departments might like to try a similar program with variations to suit local needs.

DANIEL BLAIN, M.D.

Director of Mental Hygiene

California Department of Mental Hygiene

BOOK REVIEW

MODERN OCCUPATIONAL MEDICINE—A. J. Fleming, M.D., and C. A. D'Alonzo, M.D., Editors; J. A. Zapp, Ph.D., Associate Editor, Philadelphia, Lea & Febiger, 1960, 587 pages, \$12.00.

THIS IS THE SECOND, somewhat expanded edition of a standard reference work in industrial medicine. The volume is the labor of members of the medical department of the E. I. duPont de Nemours Company, and represents both theoretical and practical concepts of industrial health.

Although the material is directed mainly to the physician working with employees in a manufacturing industry, the volume as a whole provides a frame of reference for understanding the occupational health problems of a complex industrial environment. The first and fourth sections will be of particular interest to administrators of large mental hospitals.

The volume begins with a general orientation to industrial medicine, including its history, its services, and comments on medical examinations and records. The second section introduces preventive measures in the industrial medical programs. Among these topics are the functions of the industrial hygiene laboratory, immunizations, protective clothing, and the role of toxicological research. The third section on physical environment, work, stress, and occupational health contains chapters on the physiology of muscular work, the physical environment of the work setting with special reference to radiological and noise hazards, and comment on the evaluation of physical stress in industry. Specific services allied to oc-

cupational medicine are covered in the nine chapters that make up the fourth section. Included in this section are comments on the medical-legal aspects of occupational medicine, the rehabilitation of the alcoholic in industry, and the specific problem inherent in low back syndromes, as well as chapters on safety and sanitation and the role of the industrial nurse. Surgical considerations are also touched upon. The section on toxicology is of particular and specific interest to members of the chemical industry, since it emphasizes chemical health hazards. The two final chapters deal with the problems of acute poisoning and vital statistics.

The four chapters in the section on psychiatry are titled "Effective Discipline Promotes Mental Health," "Practical Application of Psychiatry to Industry," "Mental Illness," and "Emotional Factors in Skin Disease." This section is, on the whole, disappointing.

The first chapter, by the former chief of psychiatry for duPont, Dr. F. W. Dersheimer, is well summarized by its title, "Effective Discipline Promotes Mental Health." By this, the author does not mean a simple useful matter of setting limits for employees, but rather suggests that discipline is a universally applicable psychotherapeutic tool by which the management of an organization can participate towards the resolution of an overwhelming majority of mental illnesses. Dr. Dersheimer apparently ignores a wide body of psychiatric concepts, and favors instead a unitary theory which holds that early and consistent discipline can effectively prevent all functional mental disease. This theory is based on his experience among the Arawak Indians of British Guiana.

The succeeding chapters by Drs. Gerald Gordon and Sanford Rogg, the two psychiatrists currently on the staff of the duPont Medical Department, offer occasionally interesting comments on applications of psychiatry to industry. The material is, however, directed toward the industrial physician, and will be found quite superficial by professionals in the mental health disciplines.

The chapter, "Emotional Factors in Skin Disease," by A. Blau contains a useful discussion by an industrial physician of common dermatological problems seen in a large industrial plant.

In reading *Modern Occupational Medicine*, one obtains an excellent overview of the experiences of a well recognized program of occupational medicine. As background reading to the understanding of problems frequently occurring in industry, it is a useful volume. Comments on the organization of industrial medical services make it a helpful treatise for any administrator embarking on a health program for employees.

ALAN A. McLEAN, M.D.

FILM REVIEWS

Instead of the usual film reviews, this month's film column will provide a round-up of films available from the Mental Hospital Services' Film Library—a film source for all full subscribers to the A.P.A. Mental Hospital Serv-

ices. Because this section includes information of films for various educational purposes, as well as details for booking films, readers are respectfully urged to pass it along to hospital personnel responsible for selecting and ordering films.

ABOUT THE FILM LIBRARY

At present, 31 titles are listed in the library's catalog. Because most mental hospitals use films for inservice training, the majority of the library's films were selected to fit into training programs. The following titles, for example, all deal with specific treatment methods: *Psychotherapeutic Interviewing Series*, *Activity for Schizophrenia*, *RX Attitude*, *Activity Group Therapy*, *Man to Man*, *Working and Playing to Health*, *Back into the Sun*, *Out of Darkness*, *Psychiatric Nursing*, and *A Positive Approach to Psychiatric Patients*. All would be appropriate for showing to student nurses and aides to illustrate the therapeutic roles of various members of the hospital staff.

The following films illustrate types of mental and emotional disturbance: *Seizure* (epilepsy), *David—Profile of a Problem Drinker*, *Faces of Depression*, and *Natural History of Psychotic Illness in Childhood*. There are also films on psychodynamics and self-understanding: *The Feeling of Hostility*, *The Inner Man Steps Out*, *Mr. Finley's Feelings*, *Unconscious Motivation*, and *Broken Appointment*.

There is a sizeable group of films on special subjects: *Someone Who Cares* and *The Human Side* show volunteers at work on the wards; *Eternal Children* covers many aspects of mental retardation; *Bitter Welcome* presents some of the problems encountered by the discharged mental patient; *The Gentle Warrior* tells the story of the hospital reformer, Dorothea Lynde Dix; *Back to Life* is about rehabilitation; and *Booked for Safe-keeping* shows the proper handling of disturbed patients before hospitalization. These films, in addition to their specialized uses, would provide good orientation for new employees.

Some films in the miscellaneous category could serve a variety of purposes. *The Owl and Fred Jones*, an animated cartoon about habit change, could be used by nursing supervisors to inculcate better nursing routine habits in student nurses and aides. It could also be used with the general public as a discussion film. *SKF Psychiatric Newsreels #1* and *#2* would interest hospital staffs as well as various professional groups in the outside community.

Most of the films listed above could be used in special educational programs outside of the hospital. Clergymen, physicians in general practice, pediatricians, and teachers are only a few of the professionals who would be interested in them. These films could also be shown to students of medicine, psychology, and social work. *Someone Who Cares* and *The Human Side*, two films about the work of volunteers in mental hospitals, could be used to help recruit volunteers. *Bitter Welcome* and *Back to Life* might profitably be shown before prospective employers of discharged patients. *Booked for Safe-keeping*, a recent addition to the library, is intended spe-

critical for showing to police officers, since in many communities they bring patients to the hospital. *The Gentle Warrior* is an excellent film to show to the general public on such occasions as Open House Day or Mental Health Week since it helps to interpret the mental health movement. (Incidentally, the Film Review Editor would appreciate receiving reports from readers on unusual uses of films. Reports on especially interesting film programs will be shared with other readers of this column.)

HOW TO ORDER FILMS

Films may be obtained (by full subscribers only) at no charge except for postage and handling. Prospective film users must, however, use the film booking forms found in the back of the film catalog. Complete instructions for booking films are given in the front of the catalog. To avoid disappointment, subscribers should request films three weeks in advance and should give three choices of dates. The catalog also contains complete descriptions of the films and suggestions for using them. Subscribers may request additional catalogs and booking forms from the A.P.A. Mental Hospital Services at any time.

JACK NEHER

Mental Health Materials Center

CURRENT STUDIES

This column lists investigations of interest to mental hospital personnel. Authors have agreed to make copies of their papers available. Requests should be sent to them directly, with 25¢ for postage and handling. The following papers were read at the 117th Annual Meeting of the A.P.A.

A NEGLECTED DOCUMENT — THE MEDICAL RECORD OF THE STATE PSYCHIATRIC HOSPITAL PATIENT (See also p. 29)

A comprehensive study of a state mental hospital medical records department. Copies are available from Bruno Radauskas, M.D., Superintendent, Spring Grove State Hospital, Baltimore 28, Md.

ORGANIZATION OF PUBLIC MENTAL HEALTH SERVICES

The study reviews and discusses the arguments for two organizational patterns of public mental health services and their advantages and disadvantages. Copies may be obtained from

Joseph J. Reidy, M.D., Assistant Commissioner, Maryland Department of Mental Hygiene, Baltimore 1, Md.

CAPTIVE OUTPATIENTS: A PSYCHOTHERAPY PROGRAM FOR PAROLEES

The project described in this paper was designed to meet the treatment problems posed by adult male offenders who were on parole with the condition that they accept outpatient treatment. Special problems of treating these "captive patients" are discussed. Copies of this study are available from M. Robert Harris, M.D., Director, Outpatient Department, The Langley Porter Neuropsychiatric Institute, San Francisco 22, Calif.

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1. Finkle, L. P., and Reyna, L. J.: J. Clin. & Exper. Psychopath. 19:7 (Mar.) 1958.

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NEWS & NOTES

CERTIFICATION EXAMINERS REPORT

FRANCIS J. O'NEILL, M.D., Secretary of the A.P.A. Committee on Certification of Mental Hospital Administrators, announced that out of 12 candidates the examiners certified 7 during the A.P.A. Annual Meeting at Chicago in May. Two failed, and 3 others will be re-examined upon application.

Since the first examinations, held in Minneapolis in October, 1954, the Committee has certified 97 psychiatrists as mental hospital administrators by examination, and admitted 563 under the grandfather clause.

The next examination will be held on Sunday, May 6, 1962, in Toronto, Canada, immediately before the 118th Annual Meeting of the A.P.A.

VESTERMARK FELLOWSHIPS RESUMED

THE A.P.A. SMITH, KLINE & FRENCH Foundation Awards Committee announces that the Vestermark Fellowships have been resumed with the aid of an additional grant from the foundation. A Vestermark Fellowship provides a stipend of \$600 to a medical student for ten weeks of full-time service in a public mental institution during the summer months. Grants are also available for part-time service during the medical-school term.

Applications for the summer of 1962 should be submitted by October 1, 1961, to David A. Young, M.D., Chairman, at the A.P.A. Central Office, 1700 18th St., N. W., Washington 9, D. C.

ACKNOWLEDGEMENT

Because of our editorial policy to use bibliographies as rarely as possible, acknowledgement was not made for the contribution of Stephen Jon Golburgh to the article, "Laboratory For Practical Rehabilitation," in the April 1961 issue of *MENTAL HOSPITALS*.

CORRECTION

In the April 1961 issue of *MENTAL HOSPITALS* an error occurred in the article, "Philosophy—Function—Form." Line 22, column two, page 15 should read: "... small twenty-one bed ward for adults, and two beds for children . . ."

PEOPLE & PLACES

CALIFORNIA: G. Lee Sandritter, M.D., has been appointed superintendent and medical director of Atascadero State Hospital.

A new mental health clinic opened recently at Fairfield with Donald P. Wilson, M.D., as clinic chief.

QUARTERLY CALENDAR

A.P.A. ANNUAL MEETING

1962 May 7-11, Royal York Hotel, Toronto, Canada (118th)
1963 May 13-17, Ambassador Hotel, Los Angeles, Cal. (119th)

A.P.A. MENTAL HOSPITAL INSTITUTES

1961 Oct. 16-19, Sheraton-Fontenelle Hotel, Omaha, Neb. (13th)
1962 Sept. 25-27, Americana Hotel, Miami Beach, Fla. (14th)
1963 Sept. 23-26, Sheraton-Gibson Hotel, Cincinnati, Ohio (15th)
1964 Sept. 28-Oct. 1, Hotel America, Boston, Mass. (16th)

CANADIAN MENTAL HEALTH SERVICES INSTITUTE

1962 January 15-18, Chateau Laurier Hotel, Ottawa, Ontario (2nd) (Inq. Dr. V. E. Chase, Canadian Psychiatric Assn., Suite 103, 225 Lisgar St., Ottawa 4, Ontario)

OTHER PROFESSIONAL MEETINGS

AMERICAN GERIATRICS SOCIETY, Annual Meeting, June 22-23, The Waldorf-Astoria, New York City. (Inq. Dr. R. J. Kramer, Sec., 2907 Post Rd., Warwick, R. I.)

AMERICAN MEDICAL ASSOCIATION, Annual Meeting, June 26-30, New York City.
INTERNATIONAL MEDICAL CONFERENCE ON MENTAL RETARDATION, early July, Vienna, Austria. (Inq. Dr. Ella Langer, Div. Maternal & Child Health, State House, Augusta, Maine.)

ROYAL MEDICO-PSYCHOLOGICAL ASSOCIATION, Annual Meeting, July 4-7, Belfast, Northern Ireland.

AMERICAN ASSOCIATION FOR REHABILITATION THERAPY, Annual Meeting, Scientific and Clinical Conference, July 10-14, Indiana Univ. Medical Center and Sheraton-Lincoln Hotel, Indianapolis, Ind.

INTERNATIONAL PSYCHO-ANALYTICAL ASSOCIATION, Congress, July 30-August 3, Edinburgh, Scotland. (Inq. Hon. Sec., 37 Albion St., Hyde Park, London, England.)

INTERNATIONAL CONGRESS OF PSYCHOTHERAPY, August 21-26, Vienna, Austria. (Inq. Dr. W. Speil, Lazarettgasse 14, Vienna 9, Austria.)

INTERNATIONAL CONGRESS OF GROUP PSYCHOTHERAPY, August 24-27, Paris, France. (Inq. Dr. W. J. Warner, P.O. Box 819, Grand Central Sta., New York 17, N.Y.)

WORLD FEDERATION FOR MENTAL HEALTH, International Congress on Mental Health, August 30-September 5, Paris, France. (Inq. Secretary General, WFMH, 19 Manchester Street, London W.1, England.)

AMERICAN PSYCHOLOGICAL ASSOCIATION, Annual Convention, August 30-September 6, New York, N.Y.

ILLINOIS: **Meyer Brown, M.D.**, is now head of the division of nervous and mental disorders at Evanston Hospital in Evanston.

Sophie N. Leschin, M.D., assistant superintendent of the Jacksonville State Hospital, Jacksonville, has been appointed acting superintendent.

Cleve C. Odom, M.D., many years a state hospital superintendent, has left retirement to join the staff at Anna State Hospital, Anna.

KANSAS: The State Department of Social Welfare has announced the appointment of **Richard L. Meadows, M.D.**, as assistant director of institutions, Division of Institutional Management.

Frank V. Smith, M.D., has been named superintendent of Larned State Hospital. Dr. Smith replaces **James T. Naramore, M.D.**, who has retired.

Paul Feldman, M.D., director of research and education at Topeka State Hospital, has been appointed to a committee that will develop an organizational framework for a new, national

organization to be called "American Association of Psychopharmacology."

J. Luis Ibarra, M.D., is acting clinical director of Osawatimie State Hospital.

WASHINGTON, D. C.: **Harold L. Sheppard, Ph.D.**, succeeds **Sidney Spector** as staff director of the Senate Special Committee on Aging. Mr. Spector has resigned to accept the appointment of director, Division of Housing for the Elderly, Housing and Home Finance Agency.

Lawrence G. Christianson, M.D., former chief of medical service, Ft. Meade (S. Dak.) VA Hospital, is now assistant director of medical service for the VA. In Washington, Dr. Christianson will furnish nationwide, professional leadership for medical service in the VA's hospitals and outpatient clinics.

CANADA: The **Canadian Psychiatric Association** has moved into new offices. The address is now: Suite 103, 225 Lisgar St., Ottawa 4, Ontario.

HERE & THERE: **Robert E. Gard-**

ner, M.D., superintendent of Springfield State Hospital, Sykesville, Md., retired June 1.

George L. Driver, M.D., has replaced **Marvin Terrell, M.D.**, as head of medical and surgical services, Western State Hospital, Ft. Supply, Okla. Dr. Terrell has taken a private practice in Buffalo, Okla.

Philip G. Mechanick, M.D., has been appointed medical director of the Philadelphia Psychiatric Hospital, Pa.

James T. Laird, Ph.D., is the new chief of the psychological services department of Willmar State Hospital, Minn. Dr. Laird has most recently served as chief clinical psychologist at Spencer State Hospital, W. Va.

Francis L. A. deMarneffe, M.D., many years a staff member of the McLean Hospital, Belmont, Mass., has been appointed to succeed **Willis H. Bower, M.D.**, as associate psychiatrist. Dr. Bower has been named superintendent of the Colorado State Hospital at Pueblo.

Philip E. Ryan has been appointed executive director of the National Association for Mental Health. Mr. Ryan has been executive director of the National Health Council since 1953.

John S. Johnson, administrator at Kentucky State Hospital, Danville, since 1957, has been appointed assistant superintendent (administrative), Hawthorn State Hospital, Macedonia, Ohio.

T. J. Boag, M.D., formerly of Alan Memorial Institute of Psychiatry, Montreal, will become professor of Psychiatry and Chairman of the Department of Psychiatry at the University of Vermont, Burlington. His appointment begins July 1.

Moccasin Bend Psychiatric Hospital (Chattanooga State Psychiatric Hospital), Tennessee, opened this spring. **Nathaniel Winston, M.D.**, is superintendent.

John A. Crawford has retired as business manager of Traverse City State Hospital, Michigan.

Edward G. Billings, M.D., Denver, Colo., has been elected president of the National Association of Private Psychiatric Hospitals. **Henry W. Coe**, administrator, Morningside Hospital, Portland, Ore., is the newly elected vice-president. Dr. Billings is also the new Speaker of the Assembly of District Branches of the A.P.A.

INDEX TO ADVERTISING

JUNE 1961

To obtain further information on products advertised in this issue, please check the appropriate items below, clip this coupon, and mail to A.P.A. Mental Hospital Service, 1700 18th St., N.W., Wash. 9, D. C.

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